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The purpose of this study was to examine structural empowerment's impact on nursing outcomes. This study explored structural empowerment's influence on two quality sensitive indicators, job satisfaction and intent to stay, while also examining structural empowerment's impact on two quality outcomes, perceptions about medication errors and quality of care. This research compared these outcome measures in Magnet™ and non-Magnet facilities. Four instruments used for this study include The Conditions of Work Effectiveness-II, Job Satisfaction Scale, Anticipated Turnover Scale, and the Practice Environment Scale.

Twenty-one healthcare organizations participated in this research. Twelve organizations were Magnet affiliated whereas nine were non-Magnet. A total of 1003 nurses from Magnet hospitals completed the survey and 402 nurses from non-Magnet hospitals completed the survey. Nurses perceived their work environment to be moderately empowering in both Magnet ( $M = 20.6$ ;  $SD = 3.81$ ) and non-Magnet ( $M = 20.6$ ;  $SD = 3.86$ ) organizations. Magnet nurses reported their work environment to be satisfying ( $N = 145.89$ ;  $SD = 26.98$ ), never to rarely having a medication error (92.2%), and provided excellent care (60.6%). Non-Magnet nurses reported their work environment to be satisfying ( $N = 146.36$ ;  $SD = 27.79$ ), never to rarely having a medication error (90.5%), and provided excellent care (56.5%). Finally, nurses perceived that they would slightly agree that they would not likely be terminating their employment in their present job role.

STRUCTURAL EMPOWERMENT'S INFLUENCE ON NURSING OUTCOMES IN  
MAGNET™ AND NON-MAGNET™ HEALTHCARE ORGANIZATIONS

by

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## CHAPTER I

### INTRODUCTION

The American Nurses Credentialing Center's (ANCC) Magnet™ recognition program is the marker of distinction for hospitals when discussing excellence in care. Accompanying this designation is the feeling of an entitlement of superiority in hospital patient care outcomes and measurements as this designation is considered the pinnacle of all designations in healthcare throughout the United States (Kooker & Kamikawa, 2009). Since Magnet's inception in the 1980's, ANCC has promoted and encouraged this designation to be achieved by hospitals. Initially, Magnet was linked to recruiting and retaining nurses in order to provide superb care (Aiken, Buchan, Ball, & Rafferty, 2008; Flynn & McCarthy, 2008; Joyce & Crooks, 2007). In the early 1990's, ANCC identified Magnet hospitals as those organizations that promoted nursing excellence through work environments which promoted improved outcomes, increased job satisfaction, and reduced turnover (Caldwell, Roby-Williams, Rush, & Ricke-Kiely, 2009; Kramer, Maguire, & Brewer, 2011; McHugh & Stimpfel, 2012; Rodwell & Demir, 2013; Tuazon, 2007). Being designated as a Magnet organization provides hospitals with a robust nursing culture as hospitals strive to be the best. In 2010, approximately 7% of hospitals had Magnet status (Lake, Shang, Klaus, & Dunton, 2010). Finally, Bennett et al. (2012) reported that a substantial variation in perceptions about professional nursing governance

as Magnet hospitals scored higher than non-Magnet facilities when researched. Currently, ANCC claims that the benefits of Magnet designation include attracting and retaining top talent, improving patient care, safety, and satisfaction, and fostering a collaborative culture (retrieved on 9/14/4 from <http://www.nursecredentialing.org/Magnet/ProgramOverview>). However, do Magnet hospitals have more outstanding outcomes and superior staff compared to non-Magnet organizations as the ANCC claims?

Multiple outcomes have been evaluated when looking at Magnet organizations in comparison to other types of facilities. Empowered work environments have demonstrated lower levels of burnout and higher levels of satisfaction (Laschinger, Almost, & Tuer-Hodes, 2003). Performance and productivity have strongly been correlated with positive outcomes (Tuazon, 2007), and having structural empowerment for employees contributes to the achievement of organizational goals which include positive patient outcomes (Wagner et al., 2010). As structural empowerment is a foundational premise of Magnet, looking at outcomes related to nursing and comparing these outcomes in both Magnet and non-Magnet organizations is the purpose of this research.

Magnet believes that empirical outcomes can be achieved in hospitals that demonstrate structural empowerment, exemplary professional practice, transformational leadership, and new knowledge, innovation, and improvements (Grant, Collelo, Riehle, & Dende, 2010). As Magnet facilities are linked to superior outcomes, does one of the foundational premises of Magnet designation alone provide the evidence for the superior

outcomes being reported? In particular, is structural empowerment the source of success in Magnet organizations? Structural empowerment and associated outcomes need to be reviewed and compared in both Magnet and non-Magnet organizations to see if a difference truly exists. Therefore, structural empowerment's influence will be examined more thoroughly to see if this concept impacts specific nursing outcomes in both types of organizations.

### **Empowerment Defined**

The concept of empowerment has existed for a long time as documentation of this term originated in the 17<sup>th</sup> century (McCarthy & Freeman, 2008). Ellis-Stoll and Popkess-Vawter (1999) referenced empowerment back to the 18<sup>th</sup> century as they correlated this concept to some type of process in which an individual displayed power for a purpose to develop practical healthy behaviors. McCarthy and Freeman (2008) iterated that this concept did not actually originate until the 1920's when the civil rights' movement occurred and was not thoroughly discussed or debated about its' applicability until the 1970's; however, the authors did believe that this concept was instrumental for nursing as it can influence patient safety, quality care, and equitable access to care (McCarthy & Freeman, 2008).

Empowerment has been defined, studied, and researched by many individuals in multiple disciplines. Chandler (1992) believed that empowerment involves enablement to perform the job effectively as the individual uses power to control, influence, and provide domination over the job. In empowerment, the individual has to obtain some power which promotes self-confidence. If no power is obtained, the individual is more

apt to consider themselves as not being viewed or recognized by the organization (Chandler, 1992).

### **The Two Main Types of Empowerment**

Empowerment is a difficult concept and has an array of multiple definitions. McCarthy and Freeman (2008) identify three different types of frameworks of empowerment. First, community empowerment involves correcting the balance of power by increasing resources through communication and negotiation. Second, psychological empowerment entails gaining mastery of the self. Third, organizational or structural empowerment implies that the entire organization is involved with the individual having access to information, resources, support, and opportunities (McCarthy & Freeman, 2008). Even though many types of empowerment exist, only two types of empowerment, which associate with the workplace, resonate predominantly throughout the literature. Psychological and structural empowerments are those two types. Even though empowerment can be considered a process or an outcome, this concept has been researched and studied with multiple measureable outcomes. Structural empowerment involves looking at essential organizational structures such as access to information, opportunity, resources, and support as well as formal and informal power that provides nurses with the chance to accomplish work in a meaningful way (Kanter, 1979; Laschinger, 2008), whereas psychological empowerment involves nurses being consumed with personal beliefs such as meaning, self-determination, competence, and impact in completing work (Spreitzer & Quinn, 2001). Both types of empowerment can

contribute positively to the workplace environment, but structural empowerment appears to affect the work environment more predominantly from an organizational standpoint.

### **Structural Empowerment**

Structural empowerment in the organization is characterized by access to support, resources, information, and opportunity with formal and/or informal power also being included (Laschinger, 2008; Laschinger, 2013; Laschinger, Finegan, Shamian, & Wilk, 2001). Structural empowerment is linked to one of the foundational premises for Magnet facilities. Nurses who demonstrate structural empowerment have been linked with improved productivity, strengthened motivation, and job satisfaction as employees identify workplace problems, enhance decision-making skills, and increase organizational learning. Laschinger (2008) affirms that empowerment is defined as conditions in the workplace that enable optimal job performance.

Structural or organizational empowerment has been correlated to be effective in improving job satisfaction scores and job retention rates among nurses in acute care (Laschinger, Leiter, Day, Gilin-Oore, & Mackinnon, 2012). With several nurse scientists having investigated outcome measures directly associated with workplace empowerment (Laschinger, 2008; Laschinger et al., 2012; Laschinger, Leiter, Day, & Gilin, 2009; Laschinger, Wilk, Cho, & Greco, 2009; McDonald, Tullai-McGuinness, Madigan, & Shively, 2010), understanding how sensitive the workforce can become when employees leave the organization is important. With cost and time being paramount in the training of a new nurse, understanding this concept is very important for hospital administrators. Due to lack of experienced applicants, hospital administrators become desperate to fill

voids as workloads increase. Does this workload contribute to nurses feeling appreciated and satisfied in the work environment? Nurses tend to display job satisfaction and remain in their jobs when nurses have control over the challenging work environment (McDonald et al., 2010), but this control becomes nonexistent if staffing is inadequate.

### **Significance of Structural Empowerment**

Structural empowerment has multiple outcomes associated with this concept. Outcomes include commitment, engagement, job satisfaction, job retention, motivation, patient care quality, productivity, and work engagement to list only a few. Each of these outcomes can be correlated with other outcomes associated with this concept. When the nurse exhibits job satisfaction, the employee is more likely to remain in their current job role and within the organization. The employee nurse is committed to the organization and the outcomes set forth by the company. As healthcare organizations attempt to meet goals, the hospital desires to have the most experienced and trained staff that feel empowered in making the right decisions that benefit the company (Cowden & Cummings, 2012). Plus, having experienced nurses in the workplace contributes to knowledge and experience guiding safe practice.

Structural empowerment in the organization is characterized by key foundational pillars described by Kanter. Kanter believed that employees need to have access to support, resources, information, and opportunity along with formal and informal power when desiring to be empowered (Laschinger, 2013; Laschinger et al., 2001). Laschinger (2008) avows that nurses who are provided these components of structural empowerment perform their jobs at optimal levels. A strong, sound healthy relationship is developed

between the individual and the employer (Cowden & Cummings, 2012). The employer wants the committed employee, and the committed employee wants trust in the organization. As employers look to the future for financial gains, it is imperative that nurses are retained and satisfied. As higher satisfaction scores are achieved, the organization will create a work environment where nurses will be empowered through autonomy, decision-making, and confidence in the work environment (Laschinger, Purdy, & Almost, 2007).

Hospitals need to provide work environments where nurses are empowered structurally. Benefits of nurses who are structurally empowered allow employees to prosper for the organization which in turn allows for both parties to be satisfied. Gibson (1991) implies that empowerment is a transactional, dynamic concept because this concept focuses on solutions and not problems. Empowerment allows for sharing of power, develops thinking, and achieves autonomy. To be successful in the work industry, all organizations need to promote empowerment with their employees.

### **Workforce**

All hospital organizations desire similar outcomes for their institution as businesses seek to be successful in a changing environment. When looking at empowerment in the hospital work environment, issues exist that all organizations desire to solve when evaluating nursing. The main issue is having the right workforce. The workforce has to have key players, but these key players have to be satisfied when addressing company goals. Satisfaction scores, regardless if patient related or employee related, are yearned for by hospital administrators. Healthcare organizations desire for

these scores to be high as reimbursement could be related. To address the issue of having patient and employee satisfaction scores high, the work environment has to be conducive and attractive for nurses. Nurses need to feel they are working in an inviting atmosphere which then allows them to provide a welcoming and comfortable atmosphere for the patient. Having structural empowerment enables nurses to maintain satisfaction at work while also contributing to overall organizational outcomes like patient quality or staff satisfaction (Cowden & Cummings, 2012; Davies, Laschinger, & Andrusyszyn, 2006). Supporting a work environment that provides structural empowerment allows for growth within the company and growth by the company (Cowden & Cummings, 2012). Healthcare organizations need to acquire the right people, train them, and provide the necessary components to the employees so that the individual and organization will be successful (Piersol, 2007). In essence, structural empowerment will enhance quality of care and the customers will be satisfied (Laschinger & Finegan, 2005). Nursing-sensitive indicators, such a job satisfaction and intent to stay, reflect patient outcomes that are affected by nursing care (Burston, Chaboyer, & Gillepsie, 2014; Maas, Johnson, & Morehead, 1996; Montalvo, 2007; Thompson, 2008).

### **Job Satisfaction**

Job Satisfaction is defined as an individual enjoying their work while having adequate resources and support (Davies et al., 2006). Job satisfaction is a necessity for improving work performance. Nurses that report a higher level of job satisfaction have a greater likelihood to remain in their current organization (Giallonardo, Wong, & Iwasiw, 2010). Even though no specific definition has been linked to job satisfaction with nurses,

multiple definitions have been linked to what job satisfaction entails. Job satisfaction has been associated with personal fulfillment, desired personal outcomes, positive affect toward one's role (Hayes, Bonner, & Pryor, 2010).

### **Intent to Stay**

Intent to stay is defined as the likelihood of an individual continuing employment with their current organization (Cowden & Cummings, 2012). Intent to stay has been negatively associated with burnout as employees leave their current position to pursue other opportunities that they feel more welcoming. As nurses represent the largest percentage of healthcare workers at medical facilities, organizations desire employees to be engaged and remain in their current positions within the company so that turnover doesn't occur (Jenaro, Flores, Orgaz, & Cruz, 2010).

### **Perceptions about Quality of Care and Medication Errors**

Lundmark and Hickey (2007) state that healthcare organizations need to concentrate on adverse events, medical errors, quality of care, retention, satisfaction measures, and vacancy rates. If hospitals can conquer these areas, then the healthcare organization will be successful. Laschinger (2008) found that nurses working in empowered environments create a positive professional practice environment which leads to nurses being satisfied. Therefore, empowered nurses result in higher patient care quality. Caldwell, Roby-Williams, Rush, and Ricke-Kiely (2009) concurred that Magnet hospitals, which claim to have superior outcomes, are associated with higher levels of quality of care.

Measuring nurses' performance not only augments clinical practice but assists in attaining high quality of care and patient safety (Burston et al., 2014; Thompson, 2008). Nurses in the acute care setting need to contribute to patient safety and quality. Overall quality of care has been used to discover individual nurses' perceptions about care they are able to provide (Kramer & Schmalenberg, 2008; Letvak & Buck, 2008; Schmalenberg & Kramer, 2008). Agyemang and While (2010) state that medication safety is a worldwide problem and that medications are the most common adverse event that healthcare organizations encounter. Does this type of error contribute to nurses being stressed and dissatisfied? Blegen (2006) emphasizes that minimal studies exist that examine medication errors as a quality indicator even though concerns exist about medication safety. Medication errors as a nurse-sensitive outcome have been used as a quality indicator in several studies on the relationship between nursing and quality of patient care (Choo, Hutchinson, & Bucknall, 2010; Mansour, James, & Edgley, 2012). Voluntary reporting will be used in this research to elude nurse concerns of employment reprimand, thus resulting in a more account of errors. Nurse-sensitive indicators of quality of care and medications errors were chosen as they are specific to organizational outcomes.

Bohomol, Ramos, and D'Innocenzo (2009) investigated medication errors in an exploratory research design in a critical care environment. The most frequent types of medication errors involved were omission (71%), wrong time of administration (11.5%), and prescribing errors (4.6%). The causes of medication errors included medication not available (41%), pharmacy stocking and delivery (16.3%), and transcription errors (11%)

(Bohomol, Ramos, & D’Innocenzo, 2009). Do these types of problems contribute to nurses being dissatisfied as a result of a possible lack of empowerment in the workplace?

Leggat, Bartram, Casimir, and Stanton (2010) investigated job satisfaction and psychological empowerment on the relationship between high work systems and nurses’ perceptions of the quality of care provided. Results showed psychological empowerment fully mediated the association between high performance work systems and perceptions of quality of care whereas job satisfaction moderated the association between high performance work systems and quality of care (Leggat, Bartram, Casimir, & Stanton, 2010).

### **Magnet Organizations**

Magnet is a designation that the ANCC has provided to healthcare organizations that have elected to put excellence forthright in patient care. Accompanying this designation is the feeling of superiority in hospital patient care outcomes (Kooker & Kamikawa, 2009). With the largest healthcare profession representing over 2.5 million nurses in the workforce (Ericksen, 2009; Rodwell & Demir, 2013), outcomes from organizations need to be distinct and attractive to the customers involved in the healthcare industry. Magnet believes that empirical outcomes can be achieved in hospitals that practice in four domains. These domains are structural empowerment, exemplary professional practice, transformational leadership, and new knowledge, innovation, and improvements (Grant et al., 2010). As Magnet facilities are linked to superior outcomes, does one of the foundational premises of Magnet designation alone provide the evidence for the superior outcomes being reported?

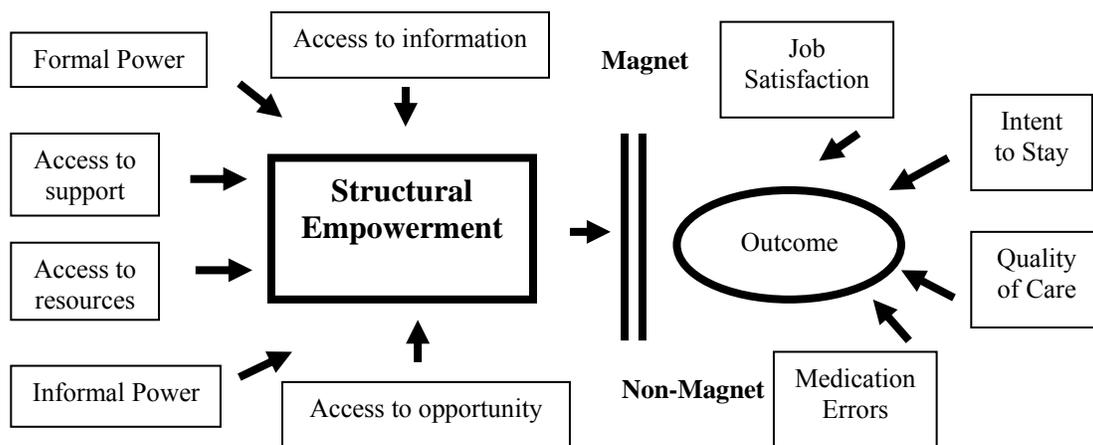
## **Purpose**

The purpose of this study was to examine structural empowerment's impact on nursing outcomes. This study explored structural empowerment's influence on two quality sensitive indicators which were job satisfaction and intent to stay. Additionally, the study examined structural empowerment's impact on two quality outcomes which were perceptions about medication errors and quality of care. This research compared these outcome measures in Magnet and non-Magnet facilities.

## **Conceptual Model**

As empowerment's definition is identified, Kanter's structural empowerment becomes the primary empowerment theory within the workplace. Kanter, renowned for her theory within the business sector, provides insight about empowerment and organizational commitment (Kanter, 1977). Kanter's structural empowerment theory provides the foundational work for many nurse scientists as her theory involves managers taking specific actions to create high quality work environments that foster trust and enhance work effectiveness (Kanter, 1977; Laschinger et al., 2012; Stein & Kanter, 1980). Kanter's theory imparts a foundational premise in which motivated employees seek a committed work relationship (Laschinger, Wong, & Greco, 2006). The four components contributing to this healthy work relationship include access to support, resources, information, and opportunity with formal and informal power being essential to this phenomenon (Cowden & Cummings, 2012; Laschinger et al., 2012; Laschinger, Wilk et al., 2009; McDonald et al., 2010; Stein & Kanter, 1980). Kanter hypothesizes that access to these factors contribute to professional growth and organizational goal

achievement (Kanter, 1977; Laschinger & Havens, 1996; Stein & Kanter, 1980). Also, formal and informal powers are imperative to this theory and assist with accomplishing goals for the organization (Chambers & Thompson, 2008). Formal power is defined by how nurses perceive their job role in terms of flexibility, visibility, and importance of the job in terms of creativity and innovation whereas informal power provides the nurse with the opportunity to establish networks with peers, sponsors, and subordinates (Davies et al., 2006; McDonald et al., 2010). By having the four structural components along with both types of power, the nurse can become empowered within the work setting which allows organizational goals to be accomplished (see Figure 1).



*Figure 1. Conceptual Framework Based on Kanter's Structural Empowerment.*

Kanter's Structural Empowerment Theory is the most popular theory researched and discussed throughout the literature. This theory has been referenced in many research studies as specific outcomes and measures have been linked to this framework as indicated by many studies (Castro, Periñan, & Bueno, 2008; Hauck, Griffin, &

Fitzpatrick, 2011; Krapohl, Manojlovich, Redman & Zhang, 2010; Wong & Laschinger, 2013; Yang, Liu, Huang, & Zhu, 2013; Young-Ritchie, Laschinger, & Wong, 2009).

Kanter, renowned for her theory within the business sector, provides insight about empowerment and organizational commitment (Kanter, 1977). Kanter's structural empowerment theory provides the foundational work for many nurse scientists as this theory involves managers, leaders, and administrators taking specific actions to create high quality work environments that foster trust and enhance work effectiveness (Kanter, 1977; Laschinger et al., 2012; Stein & Kanter, 1980). In this theory, work behaviors are created in response to the composition of the work environment and not due to the characteristics of the individual (Laschinger, Sabiston, & Kutzcher, 1997; Ridley, Wilson, Harwood, & Laschinger, 2009). This theory of structural empowerment in organizations provides a useful theoretical framework when examining the nursing work environment and the ways nurses respond to their work experiences and environment.

Stein and Kanter (1980) maintained originally that key aspects of the structural empowerment theory involved individual effectiveness, behaviors, motivation to perform, and opportunities. Behaviors included opportunities to advance and ability to utilize resources so that organizations would be able to react appropriately (Stein & Kanter, 1980). According to Kanter, when the organization provides structural components, employees are more effective on the job and feel good about the tasks that they are doing (Manojlovich & Laschinger, 2007). A sense of team between the employee and employer is produced. Results can be seen through patient and staff outcomes. Control over work conditions has been linked to work effectiveness (Hauck et

al., 2011; Laschinger et al., 1997). Kanter believed that employees want to be involved within the workplace. When employees are faced with work obstacles such as lack of growth and development, they will become disengaged and seek satisfaction in other places. Employees want opportunities to learn, enjoy, socialize, and express themselves with challenging jobs; however, employees will look elsewhere if they become frustrated (Kanter, 1979).

Kanter's Structural Empowerment Theory involves focusing on the organization and the work environment instead of the individual. This theory imparts the foundational premises that an individual must have access to structural components in order for the business to thrive. These components include support, resources, information, and opportunity. As these structural determinants are provided in the organization, the organization becomes successful because the employees are more satisfied and committed to the goals of the company due to the components that they have that support their role. The individual develops a mentality that their work is meaningful. This theory has been used to link the concept of empowerment to several measurements such as burnout, engagement, incivility, intent to stay, job satisfaction, job tension, organizational trust, productivity, retention, work effectiveness, work quality (Cowden & Cummings, 2012; Hochwalder, 2008; Laschinger, 2008; Lee & Cummings, 2008; McDonald et al., 2010; Stein & Kanter, 1980; Young-Ritchie et al., 2009). It is important to have structural empowerment in the workforce as companies not only want to be successful, but they want their employees to be satisfied. There can be overlap with psychological

empowerment, but this type of theory focuses mainly on establishing the healthy work environment.

Kanter's Structural Empowerment Theory includes empowerment being developed within the organization and not just with the individual. Even though the individual is a key component about the success of the company, this type of empowerment focuses on the components that make the organization successful. The structural components are established to assist in the work environment of the entire company, not just on the individual. The literature shows how important these components are for maintaining a healthy work environment unlike psychology empowerment where the focus is on the individual. Structural empowerment entails a process that focuses on the employee being productive and satisfied within the organization.

### **Constructs of Structural Empowerment**

The structural components of Kanter's organizational empowerment include accessing opportunities, receiving support, mobilizing resources, and accessing information. Access to opportunity implies that the employee is provided more learning, challenges, knowledge, and skills for professional growth and advancement (Laschinger, Leiter et al., 2009; Laschinger et al., 1997; Sabiston & Laschinger, 1995; Yang et al., 2013). This factor provides the employee with the opportunity to gain a new skill or to be recognized for efforts (Tigert & Laschinger, 2004). Opportunities involve those responsibilities beyond one job's description (Manojlovich, 2007) and may exist in the form of a job promotion or creation of new job skill. With nurses feeling empowered and

the structural components being provided to them, these nurses will establish more confidence in the organization as opportunities persist. Commitment to the organization can be established because the nurse has been provided empowerment in the work place.

When feedback is received by others, it means that the employee has received support (Yang et al., 2013). Receiving direction and counsel from supervisors, peers, or subordinates as well as obtaining emotional support, helpful advice, or hands-on experience provides the support that is needed for an employee to be effective in the work environment (Laschinger, Leiter et al., 2009; Tigert & Laschinger, 2004). Support allows the individual to feel that the organization has their back. An empowered nurse wants the support that the company is there for them. This will create trust between the employee and employer which leads to satisfaction in the workplace.

Access to resources implies that money, materials, supplies, time and equipment are acquired to accomplish goals (Laschinger, Leiter et al., 2009; Sabiston & Laschinger, 1995; Tigert & Laschinger, 2004; Yang et al., 2013). Having necessary equipment and supplies to complete the job will always benefit the organization. Organizations want individuals to be productive. The only way that productivity can occur is that the necessary supplies are available.

Access to information denotes having the chance to learn organizational decisions, policies, and data as well as goals (Yang et al., 2013). Information allows the individual to execute tasks to perform one's job (Tigert & Laschinger, 2004). Laschinger, Leiter, Day and Gilin (2009) emphasize that information involves having knowledge of organizational decisions, polices, and goals as well as technical knowledge

and expertise in order to be effective. By being informed, the employee feels that the company has trust in them.

With these four components of structural empowerment, the nurse will feel valued in the organization. This value will lead to a healthy environment because the employee will be satisfied. When components are stripped away such as supplies or resources, the individual will feel less empowered as their work suffers. Having necessary structural determinants will always benefit the company and will make the employee feel like they are contributing to the organization's goals.

Power is the ability of getting employees to get things done (Sabiston & Laschinger, 1995). Formal power is defined by how nurses perceive their job role in terms of flexibility, visibility, and importance of the job in terms of creativity and innovation (Davies et al., 2006; Laschinger et al., 1997; McDonald et al., 2010; Tigert & Laschinger, 2004; Yang et al., 2013). Visibility in the organization is important especially when decisions are being made. Informal power provides the nurse with the opportunity to establish networks and alliances with peers, sponsors, and subordinates so that work can be accomplished (Davies et al., 2006; Laschinger et al., 1997; McDonald et al., 2010; Sabiston & Laschinger, 1995; Tigert & Laschinger, 2004; Yang et al., 2013). Employees that depend upon power are prone to accomplish their work in a meaningful way.

Access to structural empowerment components result in increased motivation, autonomy, employee decisional involvement, organizational commitment, and job satisfaction. Consequently, employees become more productive and effective in meeting

organizational goals (Tigert & Laschinger, 2004). Kanter's theory provides a fundamental incentive for employees as advancement in knowledge and skills not only benefit the employee, but it also will benefit the organization. When employees are provided an environment that supports empowerment, work productivity becomes improved and increased. The employee will be more satisfied and committed to their work with less likelihood of feeling burnout. This feeling also will provide for better quality of care. As the structural components are provided in the workplace, the worker takes more pride in accomplishing meaningful work (Yang et al., 2013). If an employee lacks these structures, then they may feel disempowered which may contribute to burnout and mistakes in the job setting. Allowing nurses flexibility to use their knowledge to problem solve promotes more autonomous practice which creates a better working environment for the employee (Laschinger et al., 1997). If the structures exist, the nurse is more apt to be committed and motivated within the organization. This results in the nurse being autonomous and more involved in the decision-making process which overall affects the organization (Sabiston & Laschinger, 1995; Young-Ritchie et al., 2009). In other words, the nurse is able to accomplish more at work.

### **Conceptual Definitions**

1. Structural empowerment. Structural empowerment is defined as having the essential work structures (access to information, opportunity, resources, and support) that empower individuals to accomplish their work in a meaningful way (Laschinger, 2008).

2. Information. Access to information is defined by the individual having the knowledge of organizational policies and goals as well as access to the data and expertise to be efficient in the work environment (Kanter, 1977).

3. Opportunity. Access to opportunity is defined as having the potentiality for growth as challenges and rewards contribute to improved knowledge and skills (Kanter, 1977).

4. Resource. Access to resources is defined as having the ability to access materials, money, supplies, time, and equipment in order to achieve organizational goals (Kanter, 1977).

5. Support. Access to support is defined as having constructive feedback and guidance from work colleagues (Kanter, 1977).

6. Formal power. Formal power is augmented when jobs are adaptable and allows for employees to exercise ingenuity in decision-making (Ning, Zhong, Libo, & Qiujie, 2009).

7. Informal power. Informal power is derived from the development of successful relationships and communication with colleagues inside and outside the organization (Ning et al., 2009).

8. Job Satisfaction. Job satisfaction is defined as an individual enjoying their work while having adequate resources and support (Davies et al., 2006).

9. Intent to stay. Intent to stay is defined as the likelihood of an individual continuing employment with their current organization (Cowden & Cummings, 2012). Intent to say will be measured as anticipated turnover.

10. Magnet hospitals. Magnet Hospitals are those organizations designated through the ANCC that promote nursing excellence through excellent outcomes and work environments (Kramer, Maguire, & Brewer, 2009; McHugh & Stimpfel, 2012).

11. Medication errors. Medication errors are defined as medication being dispensed incorrectly or administered inappropriately (Purdy, Laschinger, Finegan, & Olivera, 2010; Sochalski, 2004).

12. Quality of care. Quality of care is defined as having a patient safety climate that promotes nurses in participating in decisions about the patient's plan of care while delivering excellent and safe care for the patient (Armstrong & Laschinger, 2006).

### **Aims and Research Questions**

The specific aims along with the associated research questions and hypotheses for this study were:

1. Assess the structural empowerment level of acute care nurses, the practice environment, and hospital traits in Magnet and non-Magnet affiliated hospitals.
  - Research Question (RQ) 1: What is the level of structural empowerment of acute care nurses in Magnet and non-Magnet hospitals?
  - Hypothesis (H) 1: Acute care nurses have higher levels of structural empowerment in Magnet affiliated hospitals when compared to non-Magnet affiliated hospitals.
  - RQ 2: What is the level of the practice environment of acute care nurses in Magnet and non-Magnet hospitals?

- H 2: Acute care nurses working in Magnet organizations score higher on the practice environment scale in comparison to nurses working in non-Magnet affiliated facilities.

2. Examine the relationships among demographic variables (age, education, approximate hours worked per week) and empowerment level of nurses working in Magnet and non-Magnet affiliated hospitals.

- H 3: Nurses with baccalaureate or higher nursing degrees have higher levels of empowerment in Magnet affiliated hospitals when compared to non-Magnet affiliated hospitals.

- H 4: As age increases, nurses have higher levels of empowerment in Magnet affiliated hospitals when compared to non-Magnet affiliated hospitals.

- H 5: Acute care nurses who work full time have higher levels of empowerment in Magnet affiliated hospitals when compared to non-Magnet affiliated hospitals.

3. Examine the influence of empowerment on anticipated turnover and job satisfaction in Magnet and non-Magnet hospitals.

- RQ 3: What is the anticipated turnover of acute care nurses in Magnet and non-Magnet hospitals?

- H 6: Nurses with high empowerment levels will have higher intent to stay levels in their current position in Magnet affiliated hospitals when compared to non-Magnet affiliated hospitals.

- RQ 4: What is the level of job satisfaction of acute care nurses in Magnet and non-Magnet hospitals?
  - H 7: Nurses working in Magnet affiliated hospitals report higher levels of job satisfaction when compared to non-Magnet affiliated hospitals.
  - H 8: Nurses with high empowerment levels are more likely to have higher satisfaction levels in Magnet affiliated hospitals when compared to non-Magnet affiliated hospitals.
4. Examine the impact of empowerment level with quality outcomes (medication errors and quality of care) reported by acute care nurses in Magnet and non-Magnet affiliated hospitals.
- RQ 5: What is the rate of making a medication error (self-reported) with Magnet and non-Magnet facilities reported by acute care nurses?
  - H 9: Nurses with high empowerment levels are less likely to make a medication error in Magnet affiliated hospitals when compared to non-Magnet affiliated hospitals.
  - RQ 6: What is the quality of care (self-reported) with Magnet and non-Magnet facilities reported by acute care nurses?
  - H 10: Nurses with high empowerment levels are more to report higher quality of care in Magnet affiliated hospitals when compared to non-Magnet affiliated hospitals.

## **Operational Definitions**

1.       Structural empowerment. Structural empowerment will be measured by the Conditions of Work Effectiveness Questionnaire-II (CWEQ-II). The questionnaire consists of 19 items and six subscales. This questionnaire uses a 5-point Likert scale. The subscales include access to information, opportunity, resources, and support as well as formal and informal power. Scores are assessed by summing items, with high scores representing high levels of the empowerment (McDonald et al., 2010).

2.       Job satisfaction. Job satisfaction will be measured by the Job Satisfaction Scale (JSS). The questionnaire consists of a 36 items designed to assess nurses' attitudes about job and aspects of the job. This measurement uses a 6-point Likert scale ranging from strongly disagree to strongly agree (Spector, 1985).

3.       Intent to stay. Intent to stay will be measured by the Anticipated Turnover Scale (ATS). This instrument consists of 12 items designed to look at the individual's perception or opinion about voluntarily leaving the organization. This measurement uses a 7-point Likert scale that ranges from strongly disagree to strongly agree (Hauck et al., 2011).

4.       Practice environment. The practice environment will measured using Lake's Practice Environment Scale of the Nursing Work Index. This instrument consists of five items that measures the components of nursing participation, nursing foundation for care, management ability, adequate staff, and collaborative relationships (Armstrong & Laschinger, 2006).

5. Medication errors. Medication errors will be measured by asking one question. This one item, which has been used to evaluate perception about medication errors, has been asked in multiple studies (Sochalski, 2004).

6. Quality of care. Quality of care will be measured by asking three questions. One item, which has been used to evaluate perceived quality of care, has been used repetitively in multiple studies (Aiken & Poghossyam, 2009; Laschinger, 2008; McHugh & Stimpfel, 2012) whereas two additional items have been used in other studies (Aiken, Buchan, Ball, & Rafferty, 2008; Ridley et al., 2009).

### **Assumptions**

Several assumptions were inherent to this study. It was assumed that nurse participants were honest and forthcoming when they answered the survey. It was assumed that the tools used accurately measured the phenomenon of interest in acute care nurses.

### **Summary**

The purpose of this study was to examine structural empowerment's influence on two nursing sensitive indicators, job satisfaction and intent to stay, and two quality indicators, perceptions about medication errors and quality of care, in Magnet and non-Magnet organizations. Kanter's Structural Empowerment theory was used to guide this research.

## CHAPTER II

### REVIEW OF LITERATURE

All hospital organizations desire positive outcomes for their organization in the transforming healthcare environment. Hospital leaders want higher job satisfaction scores, patient satisfaction scores, retention, and quality of care. These leaders want lower burnout and fewer medical care errors. Having the right staff and necessary structural components within the organization can contribute to coveted outcomes. Assuring that nurses are satisfied within the organization is a key element that can affect many outcomes such as delivery of care and turnover (Apker, Ford, & Fox, 2003; Hauck, Griffin, & Fitzpatrick, 2011; Laschinger, Leiter, Day, Gilin-Oore, & Mackinnon, 2012; McDonald, Tullai-McGuinness, Madigan, & Shively, 2010; Ritter, 2011; Vaijayanthi, Shreenivasan, & Prabhakaran, 2011). Having structural empowerment enables the nurse to maintain satisfaction while also providing to the overall goal or mission of the organization. Ritter (2011) emphasized that a stable work environment where employees are provided the necessary structures to assist in goal achievement is essential in maintaining employee satisfaction. Providing nurses with the feeling of being empowered can be beneficial to the organization.

Structural empowerment is important in the workplace when looking at positive nursing outcomes such as job satisfaction, intent to stay, and quality of care which is

supported by a plethora of studies (Batson & Yoder, 2011; Cowden, Cummings, & Profetto-McGrath, 2011; Davie, Laschinger, & Andrusyszyn, 2006; Flinkman, Leino-Kilpi, & Salanterä, 2010; Giallonardo, Wong, & Iwasiw, 2010; Hauck et al., 2011; Hayes, Bonner, & Pryor, 2010; Laschinger, Finegan, Shamian, & Wilk, 2001; Laschinger, Leiter, Day, & Gilin, 2009; Laschinger et al., 2012; McDonald et al., 2010; Ning, Zhong, Libo, & Qiujie, 2009; Ritter, 2011; Wong & Laschinger, 2013). Structural empowerment involves looking at essential organizational structures such as access to information, opportunity, resources, and support as well as formal and informal power that provides nurses the opportunity to accomplish work in a meaningful way (Laschinger, 2008). Structural empowerment has been researched with many measurements, and research has been conducted comparing Magnet and non-Magnet organizations with certain outcomes.

With understanding how important structural empowerment is and outcomes that healthcare leaders desire in the workplace, a comprehensive literature review was conducted. This chapter provides an overview of structural empowerment influences job satisfaction, intent to stay, perceptions about quality of care, and perceptions about medication errors. The review of literature extends over the last two decades as this concept has been studied and measured with a variety of outcomes. The electronic databases Cumulative Index to Nursing and Allied Health (CINAHL), Journal Storage (JSTOR), Psychological Information (Psycinfo), Medlars On-line System (Medline), and Public Medline (PUBMED) were searched. Searches were limited to researches that were available in the English language and peer-reviewed journals. Search terms used

included “burnout”, “burnout and nursing”, “empowerment”, “empowerment and nursing”, “empowerment and outcomes”, “engagement”, “engagement and empowerment”, “engagement and nursing”, “hospital reimbursement and quality”, “intent to stay”, “intent to stay and nursing”, “job satisfaction”, “job satisfaction and empowerment”, “job satisfaction and engagement”, “job satisfaction and nursing”, “Magnet”, “Magnet and non-Magnet hospitals”, “Magnet hospitals”, “Magnet outcomes”, “nurse, empower, and employment”, “satisfaction, reimbursement, and hospital”, and “work engagement”. Additional articles were located on EBSCO data base or Google Scholar that examined the terms “empowerment and nursing”, “job satisfaction and nursing”, and “intent to stay and nursing”. More than 175 articles were reviewed. This review of literature about the state of science related to empowerment included articles from other professions and disciplines that could be influential to the outcomes related to this concept. The review of literature also included articles that looked at healthcare workers and the outcomes desired for this research. This chapter will address the research that has been conducted concerning structural empowerment and the outcomes that affect nursing.

### **Empowerment According to Other Disciplines**

Empowerment has been widely discussed throughout the literature. Page and Czuba (1999) identified empowerment in terms of a social process in which individuals gain control over their personal lives by challenging assumptions that involve power, assistance, achievement, and success. These authors believed that the concept is not formulaic but that the concept takes on many meanings in its definition as individuals

attempt to gain control over their lives and situations (Page & Czuba, 1999). Ellefsen and Hamilton (2000) assent with empowerment being correlated with decision-making and delegation whereas Finegan and Laschinger (2001) believe that empowerment provides an excellent way of enhancing organizational attitudes of both genders.

Several disciplines have also defined empowerment. Oxford law defines this concept as permitting autonomous, equal, and non-discriminatory individuals to fully participate in society regardless of religious, legal, or political perspectives (“Empowerment”, 2008). Other Oxford disciplines emphasize important linkages to this concept which incorporate accountability, decision-making, job fulfillment, health promotion, motivation, productivity, responsibility, and training (“Empowerment”, 2007; “Empowerment” edited by Heery & Noon, 2009; “Empowerment” edited by Law, 2009; “Empowerment”, 2010).

### **Empowerment and Outcomes in Other Professions**

Research has shown how leaders can enhance job satisfaction in the work environment outside healthcare. Organizations looking to improve working conditions and retain employees have shown how variables or actions can influence and contribute to a better work environment. While budget limitations may avert expanding pecuniary resources, organizations should consider non-financial methods that contribute and benefit to organizational outcomes when desiring to retain and satisfy the employee. As satisfaction is warranted by both the employee and employer, a more empowering environment is desired that contributes to positive outcomes in the organization. Literature has shown how the prison system, higher education, agriculture, and the

restaurant industry have documented how empowerment and job satisfaction can be linked to better outcomes.

### **Professions Outside of Nursing**

When looking at the prison system, Farmer (2011) indicated that the work environment could be affected if employees were not empowered in decision-making. The organizational theory was the theoretical framework for this research. This framework supported three assumptions which include that decisions should not always be top down, delegation is needed in order for duties to be accomplished, and decision-making should be a shared process with employees. This research looked at relationships with supervisors, the prison system, job satisfaction, and burnout. Statistical analysis of this research included a bivariate analysis in which staff reported more positive relations in an empowered environment. However, staff burnout and staff satisfaction were not shown to have statistical significance. This research looked at a prison system in the East and the West (Farmer, 2011).

In the education system, Hermesen and Rosser (2008) found that career support and recognition for competence were found to be significant and positive indicators of job satisfaction. This researched was founded on two theoretical frameworks that included work engagement which identified with one's role and job satisfaction within the work environment. A survey was distributed to staff members in higher education in two different organizations. A total of 170 surveys, response rate of 58%, were collected for this research. Multiple linear regression analysis was performed to examine job satisfaction and engagement with work life. Career support and recognition for

competence ( $p < 0.001$ ) were found to be statistically significant with job satisfaction.

Also, working conditions ( $p < 0.001$ ) and external relations ( $p < 0.05$ ) were found to be significant and positively related to job satisfaction (Hermsen & Rosser, 2008).

Hashemi, Nadi, Hosseini, and Rezvanfar (2012) examined perceived organizational support, psychological empowerment, job satisfaction, organizational commitment, and entrepreneurial behavior in the agriculture industry. Through descriptive statistics, confirmatory analysis, and structural equation modeling, the authors found that employers must provide working conditions, in which the employees feel free, admired, motivated, and empowered. The authors found that perceived organizational support was correlated positively and significantly with psychological empowerment, job satisfaction, organizational commitment, and intrapreneurial behavior ( $p < 0.01$ ).

Personnel perceptions of their organizational support were correlated significantly more with perceptions of their organizational commitment ( $p < 0.01$ ). Job satisfaction was correlated significantly with organizational commitment ( $p < 0.01$ ). Overall, intrapreneurial behavior was correlated significantly more with organizational commitment ( $p < 0.01$ ), job satisfaction ( $p < 0.01$ ), perceived organizational support ( $p < 0.01$ ) and psychological empowerment ( $p < 0.01$ ). Perceived organizational support and job satisfaction were strong antecedents of organizational commitment than that of psychological empowerment as this has been strongly shown to improve performance and increase job satisfaction (Hashemi, Nadi, Hosseini, & Rezvanfar, 2012).

In the restaurant industry, Gill, Mathur, and Bhutani (2012) examined job satisfaction and work experience as employees covet for empowerment internationally.

Confirmatory factor analysis was the statistical analysis performed for this research. Positive relationships between job satisfaction and the employee desire for empowerment as well as work experience and employee desire to empowerment were determined. Satisfied employees are more likely to desire this concept of empowerment as decision-making is crucial in the delivery of service to patrons (Gill, Mathur, & Bhutani, 2012).

### **Empowerment in Nursing**

As other disciplines and professions provide insight as to what is empowerment, the profession of nursing links important traits to this concept. Even though empowerment has been defined by many individuals and disciplines, the concept resonates with many meanings. In nursing, many nurse scientists have defined empowerment and how this concept correlates with many outcomes. According to management, Kleiman and Droege (2006) state that employees are engaged at all organizational levels when participating in decisions for the organization. In essence, the definition of empowerment for nurses is accredited to the business world. Empowerment contributes to positive organizational outcomes as nurses address workplace problems and augment decision-making skills while feeling in control. Empowerment allows the employee to be stretched to reach their full potential (Casey, Saunders, & O'Hara, 2010).

Laschinger, Wong, and Greco (2006) performed a cross-sectional correlational study with randomized sample of 322 staff nurses in acute care hospitals in Ontario. These authors tested Kanter's organizational empowerment theory and Maslach and Leiter's work engagement model. Nurses rated total empowerment as being moderate ( $M = 18.43$ ;  $SD = 3.41$ ). Nurses rated access to opportunity as being the greatest ( $M =$

3.98; SD = 0.81) and formal power as being the least empowering factor (M = 2.49; SD = 0.85). Nurses reported high levels of burnout (M = 3.17; SD = 1.50) (Laschinger, Wong, & Greco, 2006).

Laschinger and Wong (1999) performed a cross-section correlational study using Kanter's theory. Their study tested the relationship between formal power, informal power, and access to empowerment structures in a large academic medical center in Canada. A sample size of 647 registered nurses was used for this research study. Results indicated that nurses perceived their work environment moderately empowering (M = 10.91; SD = 1.96). Nurses rated access to opportunity as being the greatest (M = 2.86; SD = 0.56) and access to information being the least empowering factor (M = 2.64; SD = 0.65). Formal power was not rated high (M = 2.64; SD = 0.65), but nurses did perceive that they did have informal power (M = 3.25; SD = 0.59). Structural equation modeling showed that productivity (the work effectiveness indicator) revealed a good fit with the data ( $X^2 = 52.014$ , GIF = 0.970, AGFI = 0.90). Results showed that informal power influenced accountability through access to all empowerment structures according to Kanter (Laschinger & Wong, 1999).

With accountability being influenced by informal power, this concept promotes professional growth. Professional growth enables the empowered nurse to accomplish meaningful work (Laschinger et al., 2012) while also achieving organizational goals (Cowden & Cummings, 2012). Laschinger, Leiter, Day, Gilin-Oore, and Mackinnon (2012) performed a quasi-experimental design. This study examined the impact of a workplace intervention on nurses' empowerment, experiences of supervisor and

coworker incivility, and trust in nursing management. The study compared intervention units in Nova Scotia and Ontario, and data was collected through the use of a questionnaire. The sample was limited to registered nurses, and data was collected at two times (Time 1,  $n = 755$ ; Time 2,  $n = 573$ ). Eight units participated in the intervention whereas 33 units were in the controlled group. Data was collected initially and then after a 6-month intervention time period. Hierarchical linear modeling was used to test the impact of the intervention. Results showed that total empowerment was correlated with trust in management (T1:  $r = 0.41$ ; T2:  $r = 0.45$ ), supervisor incivility (T1:  $r = 0.23$ ; T2:  $r = 0.25$ ), and coworker incivility (T1:  $r = 0.11$ ; T2:  $r = 0.16$ ). There were significant time-by-group interaction effects for four outcome variables: access to the support empowerment structure ( $\beta = 0.39$ ,  $p < 0.001$ ), the resources empowerment structure ( $\beta = 0.18$ ,  $p = 0.03$ ), trust in management ( $\beta = 0.03$ ,  $p = 0.007$ ), and supervisor incivility ( $\beta = -0.06$ ,  $p = 0.005$ ). The cross-level interaction for total empowerment was significant ( $\beta = 0.14$ ,  $p = 0.057$ , two-tailed). Results showed that improvements over time for support, resources, total empowerment, trust in management, and supervisor incivility variables were larger for the intervention group ( $R^2$  values from 0.02 to 0.05) when compared with the control group ( $R^2$  values from 0.00 to 0.01) (Laschinger et al., 2012).

As behaviors and outcomes are identified and cyclical, creation of a healthy work environment occurs (Laschinger, Leiter et al., 2009). Laschinger, Leiter, Day, and Gilin (2009) examined the influence of an empowering work conditions and workplace incivility on nurses' experiences of burnout and retention. Three retention outcomes were measured in 612 Canadian nurses. These included job satisfaction, organizational

commitment, and turnover intentions. Results from hierarchical multiple regression analyses showed that empowerment, workplace incivility, and burnout explained statistical significance in the three retention factors of job satisfaction ( $R^2 = 0.46$ ), organizational commitment ( $R^2 = 0.29$ ), and turnover intentions ( $R^2 = 0.28$ ). Empowerment, supervisor incivility, and cynicism most strongly predicted job satisfaction whereas emotional exhaustion, cynicism, and supervisor incivility most strongly predicted turnover intentions (Laschinger, Leiter et al., 2009).

Even though power is often correlated with empowerment, the two must not be confused. Manojlovich (2007) emphasizes that power essentially is the ability to impose one's will upon others as power is associated with control, influence, or domination and connected to legal and/or coercive behaviors. When nurses lack power in the work environment, they often become dissatisfied with their jobs and become ineffective in productivity (Manojlovich, 2007).

Being ineffective or dissatisfied may lead to burnout. Empowerment is important to have in the work environment because it enables employees to act. When nurses are empowered, they develop independent health-promoting behaviors because they are able to think, problem solve, and make autonomous choices (Ellis-Stoll & Popkess-Vawter, 1998). When employees are provided this trust, satisfaction and dedication will be exhibited by the employee. Thus, the question imposed becomes centered on what type of empowerment exists in nursing.

## **Empowerment and Magnet Organizations**

Faulkner and Laschinger (2008) showed that empowered nurses who feel more respected in the work environment will be satisfied and committed especially if the traits of autonomy, confidence, meaningfulness and a feeling of being able to have an impact in the organization are promoted. These authors examined the relationship between structural and psychological empowerment and their effects on hospital nurses' perceptions and respect from a Canadian province. The sample included 282 nurses. Findings supported Kanter's theory which emphasized that nurses perceive themselves to be empowered and are more likely to feel respected in the work environment. Nurses reported being moderately empowered ( $M = 17.8$ ,  $SD = 3.3$ ). Nurses did report opportunity as the greatest empowering structure ( $M = 4.0$ ,  $SD = 0.79$ ). Other results included nurses reporting a sense of meaning at work ( $M = 4.2$ ,  $SD = 0.76$ ) but feeling that they made no significant impact in the organization ( $M = 2.5$ ,  $SD = 0.97$ ). Structural empowerment was significantly and positively related to perceived respect ( $r = 0.47$ ,  $p < 0.001$ ) as well as each of the structural empowerment factors (Faulkner & Laschinger, 2008).

Magnet affiliated hospitals seek to identify organizational characteristics that recruit and retain the best nurses by having an excellent work environment. These organizations attempt to be superior in outcomes when compared to other facilities. Differences in the practice environments emphasized by the Magnet program are associated with positive differences in burnout, satisfaction, organizational climate, intent

to leave, and turnover (Lake, 2002; Laschinger, Shamian, & Thomson, 2001; Leiter & Laschinger, 2006).

When comparing different organizations, Laschinger, Almost, and Tuer-Hodes (2003) did a secondary analysis of three previous research studies conducted. Two studies involved staff nurses and one study involved nurse practitioners. The setting was in Canada. These authors reported about nurses' perceptions of workplace empowerment, Magnet characteristic, and job satisfaction in different work settings and showed how relationships between structural empowerment and Magnet organization characteristics were significant. Autonomy, control over practice, and positive nurse-physician relationships were shown to be significant with structural empowerment. Results were very similar to previous work conducted by Aiken in 2000. However, access to information ranked high to the overall work environment indexes ( $r = 0.52$ ). Empowerment and Magnet hospital characteristics were significant predictors of job satisfaction ( $R^2 = 0.502$ ,  $F = 26.25$ ,  $df = 2.52$ ,  $p < 0.001$ ). Their results indicated that empowered work environments support professional practice as nurses in Magnet facilities reported lower levels of burnout and higher levels of job satisfaction (Laschinger, Almost, & Tuer-Hodes, 2003).

Kramer and Schmalenberg (2004a) examined what Magnet hospital nurses meant by each of the essentials of Magnet, what it meant to practice autonomously, and what was meant by a good working relationship with physicians. These authors showed higher results for Magnet affiliated facilities over Magnet aspiring and other facilities when evaluating the support of education. The value of education, availability of school

programs, and financial assistance were reported to be higher in Magnet organizations. However, fewer rewards were considered lower in Magnet facilities. When evaluating working with nurses who are viewed clinically competent, Magnet hospital nurses reported higher scores for overall rating of competency, support of specialty certifications, preference of baccalaureate degree, and hospital reward of competency. However, peers reinforcement of one another for high quality of care was reported to be lower in Magnet hospital nurses. Finally, Magnet hospital nurses reported more positively with nurse and physician relationships in the following areas: collegial, collaborative, student-teacher with the physician being the teacher, and student-teacher with the nurse being the teacher (Kramer & Schmalenberg, 2004a).

Kramer and Schmalenberg (2004b) also found that acute care nurses in Magnet hospitals reported nurses as being more autonomous and competent in their decision-making in comparison to non-Magnet hospital nurses. In this study, autonomy was defined as being the freedom to act on choices in practice which are of best interest of the parties involved. Nurses reported higher scores for autonomy when examining accountability. Nurses rated lower scores when permission was needed first, rules inhibit decisions, and environment was too risky (Kramer & Schmalenberg, 2004b).

Kramer, Schmalenberg, and Maguire (2004a) examined what Magnet hospital nurses meant by each of the essentials of Magnet and the importance nurse-manager support and adequate staffing. Leadership behaviors and management behaviors were rated higher by Magnet nurses when compared to other facility nurse. Also, Magnet nurses ranked nurse-manager performance in the categories of teamwork, autonomy, and

nurse-physician relationships. The authors reported that Magnet hospitals have better and adequate staffing in comparison to other hospitals when looking at the variables of autonomy, care-delivery system, and cohesiveness of work groups (Kramer, Schmalenberg, & Maguire, 2004a).

In their last report, Kramer, Schmalenberg, and Maguire (2004b) report that Magnet hospital staff nurses consistently report that concern for the patient is the most important value when assessing quality of care. These authors also suggested that a culture needs to be created that will improve quality of care along with improving nurse satisfaction in all facilities. These authors collected data from over 4320 staff nurses at 26 Magnet facilities (Kramer, Schmalenberg, & Maguire, 2004b).

Tuazon (2007) discussed where evidence demonstrates positive outcomes related to Magnet affiliated facilities that allow nurses to be more autonomous and promote decision-making in practice as results showed improved patient satisfaction, enhanced physician satisfaction, and an increase in operating margin from 4% to 16% as Magnet hospitals outperformed non- Magnet hospitals. In a systematic review, Wagner et al. (2010) reported that structural empowerment, which is a component emphasized in Magnet recognition, demonstrated in health care settings supports healthier employees, reduces stress, and increases employee commitment to organizational goals, which overall culminates in improved organizational outcomes including improved patient outcomes. Ten articles were examined that represented six studies. These studies revealed associations between structural empowerment and psychological empowerment in registered nurses. This review concluded that having structural empowerment

components contributed to a strong workforce and led to higher satisfaction scores and higher retention of nurses.

Lake, Shang, Klaus, and Dunton (2010) examined the relationship between Magnet hospitals, nursing staff, and patient falls. These authors reviewed data in a cross-sectional study using 2004 National Database of Quality Indicators from over 5000 units in 108 Magnet and 528 non-Magnet hospitals. Multivariate models revealed that fall rates were 5% lower in Magnet facilities. Nursing working hours and Magnet status were significantly associated with fall rate. Productivity was negatively associated with fall rate. However, elements for nursing staff composition such as degrees, specialty certifications, and agency hours were not significantly associated with fall rates (Lake, Shang, Klaus, & Dunton, 2010).

Feltner, Mitchell, Norris, and Wolfle (2008) interviewed 40 nurses in order to evaluate effective leadership characteristics at an acute care hospital. After characteristics were determined in the interview process, a survey was distributed to 70 nurses in order to rank order each characteristic. The order of rank for the characteristics were as follows: communication skills, fairness, job knowledge role model, dependable, participative partnership, confident, positive attitude, motivation, delegation, flexibility, compassionate, employee loyal, sets objective, and negotiation. These authors revealed that effective leaders need to create a work environment where staff becomes satisfied and productive so that the organization can be successful. The characteristics determined in this study would benefit in creating a satisfying environment (Feltner, Mitchell, Norris, & Wolfle, 2008).

Hader, Saver, and Steltzer (2006) showed data where Magnet facilities provide more services and benefits when compared to other facilities. In a sample of 978 participants, surveys were distributed to collect data about the workforce. Data revealed that with each year, more nurses plan to retire and more plan to be leaving the profession on an annual basis. Providing these benefits contribute to lower turnover and greater job satisfaction. In general, it was reported that Magnet hospitals provide more support for nurses when compared to other facilities. It was also noted that Magnet organizations provided wellness programs for staff where other organizations did not. Clinical ladders were more popular in Magnet organizations (Hader, Saver, & Steltzer, 2006).

Caldwell, Roby-Williams, Rush, and Ricke-Kiely (2009) tested hypothesis associated with readiness. These authors reported that Magnet organizations provide higher quality of care, but little research is known about nurses' attitudes and behaviors in Magnet organizations. In a sample of 306 registered nurses, these authors investigated factors that influenced the willingness to embrace change needed with a Magnet affiliated status. Hierarchical linear modeling was used for statistical analysis. Results revealed that nurses are more attracted to Magnet hospitals as these facilities allow nurses to learn and excel in their skills (Caldwell, Roby-Williams, Rush, & Ricke-Kiely, 2009).

Manojlovich and Laschinger (2007) examined structural empowerment on professional factors contributing to nursing job satisfaction. Using a non-experiment design, 500 nurses were selected to be surveyed. A response rate of 66% was obtained (n = 332). Results showed that the Nursing Worklife Model explains nursing job satisfaction and adding structural empowerment to the Nursing Worklife Model will

provide additional variance to job satisfaction. Strong associations were correlated between the subscales of empowerment and the practice environment that looked specifically at the nursing worklife. This research showed that empowerment was predictive of nurses' views of 'Magnet-like' nature of the work environment which positively impacted job satisfaction (Manojlovich & Laschinger, 2007).

As hospitals strive to create a healthy work environment, the relationship between structural empowerment and outcomes has to be continually evaluated. Hospitals desire to have a working environment in which nurses are satisfied in their roles, productive in their jobs, and contribute to the success of the organization while also decreasing medical errors and improving quality of care. Where most organization offer support for continuing education, research has shown that Magnet hospitals tend to offer slightly more benefits to keep the nurse satisfied in their environment (Hader et al., 2006).

Empowerment is a process that involves the nurse to problem-solve while also allowing them to have control over their lives. Organizations desire to have healthy work environments where adequate staffing is maintained, medication errors are at a minimum, and quality of care is exceptional. As organizations struggle to balance budgets and maintain a healthy work environment, major barriers to investing in workplace strategies have been attributed to competing priorities between rising costs for care and managing health human resource issues. Lawrence (2011) reiterated that the nursing shortage would be around 20% in 2020. As organizations seek excellence in care, staff must be provided the opportunity to be empowered as nurses desire to have the tools and resources that allow for the achievement of work goals. The American Nurses

Association believes that quality of care can be directly impacted when nurses are stress-free and less burnout (Nemcek, 2007; Ridley, Wilson, Harwood, & Laschinger, 2009) which is reiterated in Magnet recognition. Also, Friese (2005) reported that adequate nurse staffing and available resources contribute to higher-quality of care being delivered to patients. Finally, Laschinger, Wong, Grau, Read, and Stam (2011) reported that empowered nurses are more likely to remain in their current nursing positions and remain committed to the achieving quality patient outcomes. Creating an environment where nurses are respected and listened to will promote job satisfaction and retain nurses while also allowing for better patient outcomes. The environment becomes magnetic in attracting the right clientele to work. A positive working environment for nursing staff is essential when desiring improved quality of patient care, and this is why the American Nurses Credentialing Center (ANCC) attributes greater safety and quality in Magnet organizations. The question posed is whether or not Magnet organizations in these outcomes when compared to other organizations.

### **Job Satisfaction**

Even though no specific definition has been linked to job satisfaction with nurses, multiple definitions have been linked to what job satisfaction entails. Job satisfaction has been associated with personal fulfillment, desired personal outcomes, positive affect toward one's role (Hayes et al., 2010). Job Satisfaction has been defined as an individual enjoying their work while also having adequate resources and support (Davies et al., 2006). Job satisfaction is a necessity for improving work performance. Nurses that report a higher level of job satisfaction have a greater likelihood to remain in their current

organization (Ingersoll, Olsan, Drew-Cates, DeVinney, & Davies, 2002). Furthermore, Giallonardo, Wong, and Iwasiw (2010) relate job satisfaction simply to the employee liking their job. Wong and Laschinger (2013) concur as they define job satisfaction as an employee's emotional reaction to a job based upon the organization taking an interest in the nurse's opinions and soliciting this information to make the organization better. It is important to involve employees in the decisions in the company as achievement of goals is accomplished.

Multiple research studies have identified correlations between job satisfaction and structural empowerment. Davies, Laschinger, and Andrusyszyn (2006) conducted a non-experimental with clinical educators in a hospital setting in Ontario. These authors examined the relationships between clinical educators' perceptions between empowerment, job tension, and job satisfaction. The sample size included 141 participants. Clinical nurse educators perceived themselves moderately empowered ( $M = 13.09$ ,  $SD = 2.28$ ). The most empowering structure was opportunity ( $M = 3.67$ ,  $SD = 0.59$ ) whereas the least empowerment factor was resources ( $M = 2.80$ ,  $SD = 0.66$ ). Clinical educators rated formal power ( $M = 3.25$ ,  $SD = 0.39$ ) and informal power ( $M = 3.38$ ,  $SD = 0.56$ ) as moderate. Job satisfaction was rated as being moderate ( $M = 3.54$ ) with greatest satisfaction being with scheduling ( $M = 4.18$ ) and least satisfaction with the balance of work and family ( $M = 3.19$ ) and control and responsibility aspects of the job ( $M = 3.20$ ). Results also revealed empowerment being a significant predictor ( $\beta = -0.598$ ,  $t = -5.689$ ,  $p < 0.001$ ). Hierarchical multiple regression indicated that there was a strong positive relationship between overall empowerment and overall satisfaction ( $r =$

0.641,  $p < 0.001$ ). Overall job satisfaction was most strongly related to access to support ( $r = 0.597, p < 0.001$ ), followed by access to information ( $r = 0.550, p < 0.001$ ), access to opportunity ( $r = 0.510, p < 0.001$ ), and access to resources ( $r = 0.470, p < 0.001$ ) (Davies et al., 2006). Having specific organizational structures in the workplace are associated with higher employee job satisfaction.

Ning, Zhong, Libo, and Qiuji (2009) examined Kanter's structural empowerment specifying the relationship among demographics, structural empowerment, and job satisfaction. A correlational, cross-sectional design was used with a sample of 650 full time nurses in six Chinese hospitals. Results showed that a positive, statistical correlation existed between structural empowerment and job satisfaction ( $r = 0.547, p < 0.001$ ) as employees that are satisfied in the work environment are more likely to demonstrate higher levels of work performance (Ning et al., 2009).

Ingersoll, Olsan, Drew-Cates, DeVinney, and Davies (2002) defined the characteristics of the nursing work force in New York and determined the nurses' level of job satisfaction and commitment to work. Surveys were distributed randomly to nurses. Sample size was 1575 nurses. Items addressed on the survey included leaving or staying within the organization, job satisfaction, and organizational commitment. Moderate to strong positive correlations were revealed between organizational commitment and job satisfaction. This research showed that nurses with high levels of job satisfaction report a likelihood of remaining at their current organization and that higher degree nurses are more likely to be satisfied in comparison to those with lesser degrees. Overall job satisfaction was significantly higher for nurses who intended to remain at the same

employer in the same job than for nurses who intended to stay at the same employer, but change jobs and nurses who intended to change employers ( $F = 16.4$ ;  $df = 5$ ;  $p < 0.001$ ). Regression analysis identified organizational commitment ( $p < 0.001$ ), but not overall job satisfaction, as predictive of intent to stay or leave (Ingersoll et al., 2002).

Laschinger, Finegan, Shamian, and Wilk (2004) conducted a longitudinal predictive study looking at linking changes of structural and psychological empowerment with job satisfaction. Using structural equation modeling, a good fit was determined from 185 randomly assigned nurses ( $R^2 = 0.616$ ,  $X^2 = 667.455$ ,  $df = 342$ ,  $IFI = 0.979$ ,  $CFI = 0.979$ ,  $RMSEA = 0.072$ ). Results showed that structural empowerment produced statistical significant changes in job satisfaction ( $\beta = 0.70$ ). When changes occurred in structural empowerment components, changes also occurred in job how nurses viewed job satisfaction. Results also revealed that employees who are empowered are generally more satisfied in their work environments (Laschinger, Finegan, Shamian, & Wilk, 2004).

Laschinger, Finegan, Shamian, and Wilk (2001) tested an expanded model based upon Kanter's work which looked at structural empowerment, psychological empowerment, job strain, and work satisfaction. A predictive, non-experimental design was utilized. The authors collected data from 404 Canadian nurses. Structural equation modeling showed a good fit for the suggested expanded model ( $X^2 = 1140$ ,  $df = 545$ ,  $X^2/df$  ratio = 2.09,  $CFI = 0.986$ ,  $RMSEA = 0.050$ ). Nurses felt that structural empowerment in the work environment resulted in higher levels of psychological empowerment environments. Providing empowering structures at work allows for

employees to be satisfied while also providing a sense that work is meaningful (Laschinger, Finegan et al., 2001).

### **Work Force**

All hospital organizations desire similar outcomes for their establishments as businesses seek to be prosperous in an ever-changing environment. Regardless if the outcomes involve employee satisfaction scores or patient satisfaction scores about quality, hospital administrators are committed and covet to deliver the best services under the best circumstances. When looking at empowerment in the hospital work environment, centralized issues exist that all organizations desire to solve when evaluating nursing. Keeping nurses satisfied in their roles and preventing nurses from leaving the company are paramount to all hospital organizations that strive to be healthy or flourishing in the healthcare environment. With estimations by 2020 that the nursing shortage could be as high as 29%, hospital administrators must provide work environments that are healthy and inviting for staff to work in (Hauck et al., 2011; Ritter, 2011). Estimated costs of orienting new nurses to the hospital average around \$62,100 to \$67,100 (Greene, 2010), and new nurse orientation can take three to twelve months to adequately train a new graduate nurse. As nurse recruiters are baffled with recruiting experienced nurses, hospital administrators face the arduous task of hiring agency or traveler nurses to fill in the vacancies while listening to disgruntled nurses who care for higher acuity patients due to increased workloads. With the stress of turnover of staff, nurses can become exhausted in the work environment which may contribute to a feeling of uneasiness.

Regardless of being dissatisfied in the work environment or if other opportunities present future employment, nurses desire to be influential and pleased within the workplace. Multiple studies have shown that acute care nurses desire satisfaction in the workplace so that the work environment becomes dynamic and strong. Having structural empowerment provides different components that enable nurses to maintain this satisfaction at work while also contributing to the overall organizational outcomes like patient quality or staff satisfaction which is supported by a plethora of studies (Cowden & Cummings, 2012; Hayes et al., 2010; Laschinger, 2008; Laschinger, Leiter et al., 2009; Laschinger et al., 2012; Laschinger, Wilk, Cho, & Greco, 2009; McDonald et al., 2010; Ning et al., 2009). Ritter (2011) stated that a healthy work environment is crucial for maintaining an environment of satisfied employees whereas an unhealthy work environment affects patient mortality and nursing outcomes. Allowing staff, such as nurses, to be involved in the ever-changing work environment can lead to favorable outcomes for the organization (Ritter, 2011) such as satisfaction. Providing nurses with the feeling of being empowered can be beneficial to the organization.

Imposing and encouraging an organization to provide structural empowerment has been instrumental in growth of organizations and individuals (Cowden & Cummings, 2012; Laschinger, Leiter et al., 2009; Laschinger, Wilk et al., 2009; McDonald et al., 2010; Ning et al., 2009). Organizations need to select the right people, develop them, and give them access to the right tools and information so that the employee and the organization can succeed and be satisfied (Piersol, 2007). And by sustaining a strong work environment, quality of care can also be enhanced (Laschinger & Finegan, 2005).

Finally, Garon and Ringl (2004) found that safe patient care was affected by the organization's work environment. Job satisfaction was highly associated with working conditions such as workload and staffing, empowerment in the work setting, and benefits offered by the company (Garon & Ringl, 2004).

The work environment is changing in healthcare. Hospital nurse to patient ratio are always being questioned and manipulated. Hospitals are seeing sicker patients and asking nurses to take care of these patients. With fewer nurses taking care of sicker patients, staff become dissatisfied which produced more stress in the environment (Laschinger & Finegan, 2005). Stress in the work environment may lead to burnout (Laschinger & Finegan, 2005; Laschinger, Wong et al., 2006).

### **Intent to Stay**

Intent to stay is defined as the likelihood of an individual continuing employment with their current organization (Cowden & Cummings, 2012). Intent to stay has been negatively associated with burnout as employees leave their current position to pursue other opportunities that they feel more welcoming. As nurses represent the largest percentage of healthcare workers at medical facilities, organizations desire employees to be engaged and remain in their current positions within the company so that turnover doesn't occur (Jenaro, Flores, Orgaz, & Cruz, 2010). Budin, Brewer, Chao, and Kovner (2013) emphasize that retaining nurses can contribute to patient safety as they surveyed nurses and established relationships between work behaviors and nursing outcomes.

Joyce and Crookes (2007) indicated that nurses are leaving the profession and new graduate nurses are staying in the profession for a limited period of time. These

authors collected data through focus groups that primarily centered on quality of care, management support, and nurse-physician relationships. Regardless of their affiliation, hospitals that desire to attract and retain nurses must look at the organizational structures and address issues that will assist in keeping nurses in their position or at the institution.

Manojlovich and Laschinger (2007) tested a modification of the worklife model. When hospital staffing is insufficient and/or the necessary components are not in place to assist the nurse, quality of care will be compromised and nurses will look elsewhere for employment (Manojlovich & Laschinger, 2007).

Nemcek (2007) performed a descriptive, correlation study with a sample of 136 nurses that looked at the relationship of job satisfaction with life and self-nurturance. Self-nurturance, career satisfaction, and life satisfaction were positively correlated with one other. As self-nurturing behaviors and career satisfaction increased, life satisfaction increased. This research found that quality of care of care is directly associated with nurses remaining in their positions (Nemcek, 2007).

### **Perception about Quality of Care and Perception about Medication Errors**

Nurses practice in many settings which include hospitals, office settings, and clinics. Nurses vary in the levels of education as well in competencies. Four focuses that the Institute of Medicine (IOM) Report of 2010 emphasized included the following: 1) nurses should practice at the full extent of their education and competency; 2) nurses should achieve higher levels of education and training through an improved education system that promotes seamless academic progression; 3) nurses should be full partners, with physicians and other health care professional, in redesigning healthcare in the

United States; and 4) effective workforce planning and policy making require better data collection and improved information infrastructure (IOM, 2011). With the Affordable Care Act mandating task groups to monitor the workforce in healthcare, the workforce must meet the demands of the staff and the changes predicted in the future.

The IOM report emphasizes that nurses work environments need to be improved while also improving safety and quality of care (IOM, 2010 October). Improving safety and quality care may include reviewing and examining the work environment and workforce staffing. As Magnet organizations are upheld to exemplify the best in healthcare, the expectation is that outcomes are superior in these organizations. Outcomes measured and evaluated can include, but are not limited to, quality of care and medication errors as well as job satisfaction and intent to stay.

Aiken and Poghosyan (2008) performed a descriptive cross-sectional study in which an evaluation of an intervention for professional practice in Armenia and Russia. Interventions included changes in nurses' practice environments, nurse reported patient quality of care, and nurse burnout based upon initiatives from the ANCC Forces of Magnet. Nurses were asked to rate on a four point Likert scale about quality of care. Findings showed improvements in the nurse practice environment that were consistent with an evolving professional nurse practice model as emphasized by the ANCC and Magnet. Markers of patient-care quality also improved over the course of the study. The authors found that practice environment improvements occurred after the intervention (Aiken & Poghosyan, 2008).

Aiken, Buchan, Ball, and Rafferty (2008) tested the impact of Magnet principles of improving work environment of nurses. After a two year implementation period of Magnet principles based upon evidence-based standards and Magnet status awarded, quality of care improved and job satisfaction increased. Quality of care and job satisfaction advanced and was attributed to improving the work environment (Aiken, Buchan, Ball, & Rafferty, 2008).

Friese (2005) examined practice environments and outcomes of nurses working in oncology in Magnet affiliated organizations. In this secondary analysis study, there were 1956 nurses involved with 305 nurses working in oncology. Twenty-two hospitals were part of this study with only seven being Magnet. Results from this study showed that oncology nurses benefited from working in Magnet organizations as outcomes tended to be superior. This research showed that adequate staffing and resources are necessary components that are needed to accomplish optimal outcomes (Friese, 2005).

Kendall-Gallagher and Blegen (2009) explored the association between certified nurses working in the hospital and risk of harm to the patients. This study involved a secondary analysis in which hierarchical linear modeling was used to determine relationships between certification rates, organization characteristics such as Magnet, staffing, and education, rates of medication errors, falls, skin breakdowns, and nosocomial infections. The setting involved critical care. Findings showed that total hours of care were positively associated to medication errors and specialty certification and competence of registered nurses are related to patient safety (Kendall-Gallagher & Blegen, 2009).

McHugh and Stimpfel (2012) examined the validity of nurses' responses about quality of care. These authors found a 10% increase in the proportion of nurses reporting excellent quality of care. This percentage increase was associated with lower odds of mortality, greater patient satisfaction, and higher composite scores of specific disease conditions. Nurses did relate quality of care with hospital performance (McHugh & Stimpfel, 2012).

Lundmark and Hickey (2007) state that the priorities in the hospital environment include quality of care, medical errors, adverse events, satisfaction measures, retention, and vacancy rates. If hospitals can grasp hold of these priorities, a healthy work environment can be established and then organization can thrive. Laschinger (2008) reported that the Institute of Medicine emphasized the importance of high quality nursing work outcomes to patient safety outcomes and the quality of nursing work environments to patient mortality (Laschinger, Shamian et al., 2001). Laschinger found that nurses who work in empowered environments are more involved in creating a positive professional practice environment which increases nurses' satisfaction in the work being provided (Laschinger, 2008). Therefore, empowered nurses result in higher patient care quality and higher job satisfaction. Caldwell et al. (2009) concurred that Magnet hospitals are associated with higher levels of quality of care (Joyce & Crookes, 2007; Powers & Sanders, 2013; Yang, Liu, Huang, & Zhu, 2013). Finally, Armstrong and Laschinger (2006) linked empowerment to Magnet hospital characteristics and stated that a positive patient safety climate with empowered nurses contribute to safe patient care, leading to fewer patient care errors.

## **Outcomes Related to Structural Empowerment**

The benefits of structural empowerment can be advantageous for organizations as job retention, job satisfaction, patient care quality, and work engagement are practical outcomes in multiple research studies (Friese, 2005; Hochwalder, 2008; Laschinger, 2008; Laschinger, Leiter et al., 2009; Laschinger, Wong, Grau, Read, & Stam, 2011; Purdy, Laschinger, Finegan, Kerr, & Olivera, 2010; Ridley, Wilson, Harwood, & Laschinger, 2009). Awareness of structural empowerment has shown not only to increase job satisfaction but also to improve staff retention rates for hospitals. As hospitals seek to maintain and hire the most qualified staff, administrators will need to demonstrate that empowered nurses are not only desired but needed. Structural empowerment refers to characteristics in the workplace that facilitate the completion of goals (Cowden & Cummings, 2012). Lethbridge, Andruzyszyn, Iwasiw, Laschinger, and Fernando (2011) showed that preparing students to be empowered will produce more effective future academic and work success.

Structural empowerment in the organization is characterized by access to support, resources, information, and opportunity with formal and/or informal power also being included (Laschinger, 2008; Laschinger, 2013; Laschinger, Finegan et al., 2001). Nurses who demonstrate structural empowerment have been linked with improved productivity, strengthened motivation, and job satisfaction as employees identify workplace problems, enhance decision-making skills, and increase organizational learning. Laschinger (2008) affirms that structural empowerment is defined as conditions in the workplace that enable optimal job performance. Cowden and Cummings (2012) concur with optimization of

job performance as structural components are demonstrated in the establishment of a healthy relationship between the individual and the employer. Employers are constantly searching for ways to retain nurses and improve nurse job satisfaction. When combined, job satisfaction and intent to quit have been shown to be negatively correlated within the workplace (Ning et al., 2009). High satisfaction scores have been correlated when nurses were provided the opportunity to express autonomy, decisions, and confidence in the work environment (Laschinger, Purdy, & Almost, 2007).

As structural empowerment is studied with nursing sensitive indicators, hospitals need to strive in empowering nurses so that these outcomes are exceptional. Nurses need to be able to have accessibility to the structural domains in order to control, influence and produce significant results while also being respected by all disciplines. In the 1990's, Chandler (1992) stated that administrators need to empower nurses by listening to their concerns and reacting as outcomes demonstrate positive results with this concept. Nurses need to have some authority over their work environment. Laschinger and Havens (1996) found that work environment structures have an impact on factors that influence employees' work effectiveness such as control over professional nursing practice and work satisfaction. Having autonomy is an important factor in nursing work. Even though empowerment may involve control over individuals or situations (Chambers & Thompson, 2008), nurses will be more effective and productive when the decisions they make are more meaningful to them (Parsons, 2004). Empowerment provides a confidence when nurses know they are influencing their own work.

## **Conclusion**

This review has examined research looking at structural empowerment, job satisfaction, intent to stay, perceptions about quality of care and medication errors, and Magnet and non-Magnet organizations. Research has confirmed that empowered nurses are satisfied when organizations have the right structures in place. Laschinger, Wilk, Cho, and Greco (2009) report that empowered nurses are more prevalent in Magnet affiliated organizations than non-Magnet facilities. When nurses are satisfied, the care being delivered is better. The nurses are more likely to remain in their job role or at the institution. Also, research to date supports that Magnet organizations have superior outcomes. However, the purpose of this research is to investigate the concept of structural empowerment with nursing outcomes in Magnet and non-Magnet organizations since a gap in literature exists.

## CHAPTER III

### METHODS

The purpose of this study was to examine structural empowerment's impact on nursing outcomes. This study explored structural empowerment's influence on two quality sensitive indicators which were job satisfaction and intent to stay. Additionally, the study examined structural empowerment's impact on two quality outcomes which were perceptions about medication errors and quality of care. This research compared these outcome measures in Magnet and non-Magnet facilities. This chapter describes the methodology of the research including the research design, setting, sample, and the procedures used for data analysis.

The measures used in this study included individual and organizational factors. Personal characteristics including structural empowerment, job satisfaction, and intent to stay were measured. Organizational characteristics including the practice environment, perception about quality of care, and perception about medication errors were also measured. Structural empowerment was measured using the Conditions of Work Effectiveness – II (CWEQ-II) instrument. Job satisfaction was measured using the Job Satisfaction Survey (JSS). Intent to stay was measured by using the Anticipated Turnover Scale (ATS). The practice environment was measured by using the Practice

Environment Scale (PES). Perceptions about quality of care and medication errors were measured by utilizing questions used in previous studies.

### **Design**

This research utilized a correlational, cross-sectional design to assess the relationship between structural empowerment and job satisfaction, intent to stay in the work setting, perceptions about quality of care, and perception about medication errors respectively in Magnet and non-Magnet affiliated hospitals. Also, the practice environment was evaluated to see if Magnet hospitals are superior in components that cater to this designation. Nursing quality data, quality of care and medication errors, were also collected. A cross-sectional design allowed data to be collected only once during a single period. An online survey was distributed to eligible nurse participants that work in both types of hospitals, Magnet and non-Magnet over a period of one month.

A cross-sectional design allowed for data to be examined at one point of time (Polit & Beck, 2012). Correlational research provides a systematic investigation of relationships between variables, without necessarily determining cause and effect (Polit & Beck, 2012). Magnet organizations are associated with higher quality of care (Caldwell, Roby-Williams, Rush, & Ricke-Kiely, 2009), and creating a working environment where job satisfaction is high and organizational structures are in place assists in retaining nurses for their industry (Hader, Saver, & Steltzer, 2006). Survey methodology was used in this study to allow a large group of nurses to participate in the research. An electronic survey ensured nurses' anonymity while providing convenience as nurses could complete the survey at any computer with internet access.

## **Sample**

The target population was nurses working at organizations that were either Magnet affiliated or non-Magnet affiliated. One organization was comprised of 14 hospitals that were located throughout North Carolina and Virginia. Another organization had six hospitals located in the central part of the state of North Carolina. One other non-Magnet rural and community based facility was included in this research. A total of 21 hospitals were used to recruit participants. All of these facilities were purposely selected as representative of Magnet and non-Magnet organizations. All of the healthcare organizations participating in this research were not for profit. The organizations invited to participate were chosen due to the proximity of the investigator's location and employment affecting approximately 6500 nurses. All nurses, including leaders as well as staff nurses, were eligible for this study. All nurses at these organizations received an invitation to participate in the research via the healthcare system's electronic email. A convenience sample was used.

## **Inclusion Criteria**

The inclusion criterion included only acute care nurses who work for the specified organization in the region as other nurses located in nearby communities would not be included. All nurses needed to be able to read English and have access to a computer. All nurses, regardless of employment status, were eligible to participate in the study. No exclusion criteria were applicable to nurses at any of facilities.

## Methods

The researcher met with the nursing research councils of the two major organizations and corresponded via electronically and telephonic to the one smaller rural facility. The meetings were conducted to obtain permission to conduct the research at their respective institutions or organizations. Nurse participants were recruited through the healthcare system's electronic mail system. An email was sent to all nurses working for the specific market of the organizations chosen. The email contained an electronic letter explaining the purpose and importance of the study. A survey link was embedded within the email which directed them to an independent website for data collection. Access to the link was available through any computer that had internet access. The survey was available for approximately four weeks for data collection. All nurses completing the survey within the allotted time frame were included. All consents were provided and submitted electronically with the submission of the survey. Only an electronic survey was used to collect data, and Qualtrics<sup>TM</sup> was the electronic instrument used for data collection. No paper surveys were collected. Nurse participants completed the survey at their convenience. Completed surveys were examined only by the investigator, research assistant, and statistician or consultant and were kept electronically. Password access to the computer data was required for security purposes. To assure anonymity, no identification codes were linked to any completed electronic surveys.

After analyzing the research questions and study hypotheses, it was determined that five hypotheses required the largest sample size for adequate statistical power to detect an association between empowerment subscales and the measure being evaluated.

A medium effect size of Cohen's  $f^2 = 0.25$  between structural empowerment level and the other measures was detected with a 2-way logistic regression with at least 80% power when the sample size was 209 nurses, assuming a two-tailed type I error = 0.00625 (i.e., 0.05/8 for the eight types of job satisfaction) and adjusting for gender, race/ethnicity, age, years in nursing, years in current nursing position, years in nursing, education level, length of shift, professional job role, typical shift worked, and average hours worked per week.

### **Human Subject Protection**

An Institutional Review Board (IRB) application was submitted for approval to the University of North Carolina at Greensboro (UNCG) IRB as well as each of the organization's IRB where the study occurred. If a facility did not have an IRB, a letter of permission was obtained by the nursing director at the facility and submitted to UNCG. All IRB(s) or letters of permission were obtained prior to beginning the study. There were minimal risks to the subjects, and an expedited review was desired. There were no experimental groups. All nurse participants collected an electronic survey that took less than 30 minutes to complete. All information collected was through the software Qualtrics™ which required password access to retrieve any data. The link to the survey used a separate uniform resource locator (URL) which was not linked to the participant's email address or Internet Protocol (IP) address. In the project guidelines and with the IRB application, all information delineated specific procedures for recruitment, informed consent, and appropriate data collection techniques. The principal investigator completed the education requirements for human subjects' protection. Recruitment of participants

was done electronically. The researcher only sought approval to conduct the research in-person throughout organizational meetings at two facilities and via telephone with one other small, rural facility. If a nurse decided to participate after explanation, full disclosure of the study requirements were provided in a participant information statement within the online survey. This statement explained the purpose, risks, benefits, and participant's right to withdraw at any time from the survey. To protect against the risk of psychological discomfort, the participants were explained that they do not have to answer any question(s) that makes them uncomfortable. The researcher reiterated that all information was anonymous and that no repercussions would occur from participating in this study. To ensure anonymity and confidentiality, no names were linked to any questionnaires. Retrieved data was stored and locked in the principal investigator's office computer with access requiring a password to review the data. The database was backed-up weekly and reviewed for all processes related to data management and security. After completion of this study, the results were reviewed and analyzed. Informed consent was obtained by nurse participants accepting the statement of research required to enter the survey.

### **Instruments**

Five instruments were used for data collection: (a) a researcher designed demographic and information form, (b) Conditions of Work Effectiveness– II (CWEQ-II), (c) Job Satisfaction Scale (JSS), (d) Anticipated Turnover Scale (ATS), and (e) Practice Environment Scale (PES). For this research study, one electronic survey was composed of four valid instrument that measure structural empowerment, job satisfaction,

practice environment, and intent to stay. The survey as designed so that the questions were presented in a non-threatening manner. This online survey began with questions about the nurse's place of employment and whether or not the healthcare organization of employment was Magnet or not. Demographic information was obtained first with demographics including age, gender, race, years in the nursing and in the role, education, and job characteristics. Question related to structural empowerment were next and then followed by questions about job satisfaction, intent to leave, and the practice environment. Lastly, five questions pertaining to perceptions about quality of care and medication errors were asked.

### **Demographic Information Form**

The demographic information form was developed for this study to obtain characteristics about the nurse participants. The individual information collected included the participant's place of employment, gender, race, age, number of years in nursing, number of years in current nursing role, number of years on the nursing unit, number of hours worked in a typical week, length of shift worked, shift of work, work status, primary unit of employment, job role, and education. Also, the individual was asked if their organization was on the pathway for excellence for Magnet. These measures were selected from a review of the literature on structural empowerment and Magnet organizations (Kramer, Maguire, & Brewer, 2011; McDonald, Tullia-McGuinness, Madigan, & Shively, 2010; Ning, Zhong, Libo, & Qiuji, 2009; Ridley, Wilson, Harwood, & Laschinger, 2009; Tigert & Laschinger, 2004).

## **Conditions of Work Effectiveness – II (CWEQ-II)**

Structural empowerment was measured by the CWEQ-II. The questionnaire consists of 19 items, composed of six subscales, and uses a 5-point Likert scale that ranges from none to a lot. The subscales include access to information, resource, opportunity, and support as well as formal and informal power. Scores are determined by summing items, with high scores representing high levels of the construct. Laschinger, Finegan, Shamian, & Wilk (2001) validated the factor structure of CWEQ-II and recommended creating a total score by summing the six subscales with the scores ranging from 6 to 30. Various research studies have reported that the Cronbach alpha for reliability for the different components of structural empowerment ranged from 0.68 to 0.93 (Armstrong & Laschinger, 2006; Ellefsen & Hamilton, 2000; Faulkner & Laschinger, 2008; Hauck, Griffin, & Fitzpatrick, 2011; Krapohl, Manojlovich, Redman, & Zhang, 2010; Laschinger, 2008; Laschinger, Almost, & Tuer-Hodes, 2003; Laschinger, Wong, Grau, Read, & Stam, 2011; Ning et al., 2009; Purdy, Laschinger, Finegan, Kerr, & Oliveria, 2010; Sabiston & Laschinger, 1995; Tigert & Laschinger, 2004). Manojlovich and Laschinger (2007) reported that content and construct validity have been established, and Tigert and Laschinger (2004) stated that validity had been substantiated by confirmatory factory analysis (Laschinger, 2008; Laschinger et al., 2011; Ridley et al., 2009). A 2-item global empowerment scale correlated positively with CWEQ-II ( $r = 0.56$ ) which supports the construct validity of the instrument (Hauck et al., 2011; Ning et al., 2009).

Multiple studies have examined nursing and structural empowerment in the hospital setting (Armstrong & Laschinger, 2006; Davies, Laschinger, & Andrusyszyn, 2006; Krapohl et al., 2010; Laschinger, 2008; Laschinger et al., 2003; Manojlovich & Laschinger, 2007; Laschinger, Purdy, & Almost, 2007; Purdy et al., 2010; Ridley et al., 2009; Tigert & Laschinger, 2004). In an exploratory study, Armstrong and Laschinger (2006) distributed the CWEQ-II to staff nurses in a small community hospital in central Canada when they examined the relationship between a safe practice environment and quality of nursing practice. Krapohl et al. (2010) used the CWEQ-II with critical care nurses working in Michigan to measure workplace empowerment. Laschinger (2008) used the CWEQ-II with staff nurses who worked in urban tertiary hospitals to examine structural empowerment's influence on quality outcomes and the work environment. Laschinger, Almost, and Tuer-Hodes (2003) used secondary analyses from three studies that used the CWEQ-II in measuring structural empowerment in staff nurses and acute care practitioners in Ontario, Canada. Manojlovich and Laschinger (2007) used the CWEQ-II when they tested Leiter and Laschinger's Nursing Worklife Model when they examined structural empowerment's impact on work environmental factors that lead to job satisfaction. Purdy, Laschinger, Finegan, Kerr, and Olivera (2010) used the CWEQ-II with acute care nurses when they examined the relationship among perceptions of the work environment and quality outcomes. Ridley, Wilson, Harwood, and Laschinger (2009) used the CWEQ-II when specifically looking at nephrology nurses' job satisfaction in correlation to empowerment. Other studies have used the CWEQ-II with

specific nurses such educators (Davies et al., 2006) and nurse managers (Laschinger et al., 2007).

### **Job Satisfaction Scale (JSS)**

Job satisfaction was measured by the JSS. This questionnaire consists of 36 items designed to measure job satisfaction, and this tool uses a six point Likert scale to evaluate responses. This instrument measures several scales which include pay, promotion, supervision, fringe benefits, contingent rewards (performance based upon rewards), operating procedures (required rules and procedures), coworkers, nature of work, and communication. Cronbach alpha reliabilities are as follow: pay (0.75), promotion (0.73), supervision (0.82), fringe benefits (0.73), contingent rewards (0.76), operating procedures (0.62), coworkers (0.60), nature of work (0.78), and communication (0.71). Total Cronbach alpha reliability is 0.91 for all facets of this instrument (Spector, 1985). The JSS was examined from the 2004 National Database of Nursing Quality Indicators<sup>®</sup> which examined job satisfaction among direct care nurses (Klaus, Ekerdt, & Gajewski, 2012).

### **Anticipated Turnover Sale (ATS)**

Intent to stay was measured by using the ATS that looks at the individual's perception or opinion about voluntarily leaving the organization. The ATS contains 12 items that uses a seven point Likert scale. The Cronbach alpha for reliability has been estimated at 0.84 with one study reported a value of 0.88 (Hauck et al., 2011). Multiple studies have examined nursing and anticipated turnover (Barlow & Zangaro, 2010; Gormley, 2011; Hart, 2005; Hauck et al., 2011; Hunt, 2014). Gormley (2011) used the

ATS with staff nurses and manager when evaluating turnover. Hart (2005) used the instrument with nurses in Missouri when looking at turnover intentions. Hauck, Griffin, and Fitzpatrick (2011) used the instrument when specifically looking at critical care nurses and turnover. Hunt (2014) provided the ATS to staff nurses and managers in non-Magnet affiliated hospitals to evaluate job satisfaction and turnover.

### **Practice Environment Scale (PES)**

The practice environment was measured using Lake's PES of the Nursing Work Index. This instrument consists of 31 items that measure the components of nursing participation, nursing foundation for care, management ability, adequate staff, and collaborative relationships (Armstrong & Laschinger, 2006). Cronbach alpha reliabilities range from 0.71 to 0.80 with subscales ranging from 0.65 to 0.84. Other studies have tested the reliability of this instrument have ranged in scores of 0.71 to 0.87 and construct validity has been established (Aiken & Poghosyan, 2009; Friese, 2005; Laschinger, 2008; Manojlovich & Laschinger, 2007; Ridley et al., 2009). Multiple studies have examined nursing and the work environment in Magnet affiliated healthcare organizations (Aiken & Poghosyan, 2009; Armstrong & Laschinger, 2006; Friese, 2005; Laschinger, 2008; Manojlovich & Laschinger, 2007; Ridley et al., 2009). Aiken and Poghosyan (2009) used the PES with staff nurses working in Armenia and Russia when they evaluated professional nursing practice. In a secondary analysis, Friese (2005) used the PES when looking at oncology units and Magnet hospitals the association between the two. Manojlovich and Laschinger (2007) used the PES with Michigan nurses when they examined the professional work environment factors.

## **Quality of Care**

Quality of care was measured by asking three questions. One item, which has been used to evaluate perceived quality of care, has been used repetitively in multiple studies (Aiken & Poghosyan, 2009; Laschinger, 2008; McHugh & Stimpfel, 2012). Two other questions will be asked in addition to evaluate quality of care (Aiken, Buchan, Ball, & Rafferty, 2008; Ridley et al., 2009). There have been no studies that report reliability or validity. Multiple studies have examined nursing and quality of care (Aiken & Poghosyan, 2009; Aiken, Buchan, Ball, & Rafferty, 2008; McHugh & Stimpfel, 2012; Nemcek, 2007; Laschinger, 2008; Ridley et al., 2009; Sochalski, 2004).

## **Medication Errors**

Medication errors were measured by asking one question. This one item, which has been used to evaluate perception about medication errors, has been asked in multiple studies (Purdy, Laschinger, & Finegan, Ker, & Olivera, 2010; Sochalski, 2004).

## **Data Analyses Plan**

The survey was developed based on a review of the literature. Qualtrics™ software was used to format and administer the survey. The data were verified and corrected when erroneous data was noted. The data were verified for missing information or questionable responses prior to further analysis. Patterns of missing data were examined to see if missing data adjustments were needed; however, no corrections were made due to missing data being dispersed and being less than 5% (Polit & Beck, 2012). If a pattern of missing data was not random, a statistician was consulted to perform sensitivity analysis for the data that was missing (Polit & Beck, 2012).

Descriptive statistics were used to describe the demographics of the population. Descriptive statistics were used to assess and compare empowerment levels of nurses at Magnet and non-Magnet organizations. Data was analyzed using SPSS 19.0 software (SPSS Inc., Chicago, IL). Descriptive statistics were performed to assess for outliers. Assumptions of analyses were checked including normality, linearity, and homoscedasticity where appropriate. The data were examined to determine if they were theoretically out of range. A two-sided  $p$ -value  $< 0.05$  was considered statistically significant.

Gender was collected categorically as nurse participants selected male or female. Race or ethnicity was also collected categorically as information provided evidence if the population was diverse or not. Age in years, years working in nursing, years in current role, and approximate hours worked weekly was collected from nurse participants with a mean score and standard deviation determined for each. These measures also were categorized into ranges to observe whether or not empowerment exists in certain demographic groups. The sole purpose of knowing if a generation gap exists between younger versus older, years of service in profession, and/or years in current role may be influential in determining if empowerment exists or is lacking for all nurses or whether this phenomenon is specific to a certain group of nurses. Identifying if high levels of structural empowerment exist or not within the organization may contribute to overall job satisfaction and the intention of the nurse to leave or not leave the organization. Education level information was collected with the sole purpose of looking at two categories, associate degree or below versus baccalaureate degree and above, to see

whether or not if a four-plus year degree nurse perceives empowerment in their work environment differently than those nurses with different education. Work status was collected according to three categories of full time, part time, and per diem. The professional roles of the nurse were categorized as staff nurse, educator or researcher, advanced practice nurse, administrator, and other to see if empowerment is perceived more by those in any job classification. Length of shift worked was analyzed accordingly to the categories of less than eight hours, eight to ten hours worked, or greater than ten hours worked per shift. The shift worked was analyzed. Shifts for this research study will be day time hours or night time hours. Magnet, non-Magnet, and pathway to excellence information were collected to see if the healthcare organizations had received the Magnet designation or if these organizations were on the pathway to receive the designation. The rationale for collecting different job characteristics and demographic data is to see whether or not a difference exists between Magnet and non-Magnet affiliated hospitals concerning empowerment, the practice environment, intent to stay and perceptions of medication and quality of care.

Descriptive statistics were also performed to determine the level of empowerment, practice environment, job satisfaction, intent to stay, self-reported medication errors, and perceptions about quality of care for acute care nurses in both Magnet and non-Magnet facilities. Structural empowerment, job satisfaction, intent to stay, the practice environment, medication errors perception, and quality of care perception were all examined by calculating means and standard deviations. Structural empowerment subscales were evaluated and the overall empowerment level was

reviewed. Job satisfaction subscales were evaluated individually as well as an overall combination score for job satisfaction. The intent to stay measurement was tabulated based upon summing the score of the items in the survey for one total score. The practice environment subscales was evaluated individually as well as the overall score for the practice environment. Perceptions of medication errors and quality of care were asked with mean scores and standard deviation be calculated.

Comparisons of the two different groups, Magnet and non-Magnet, were conducted by performing independent *t*-tests. Structural empowerment, job satisfaction, and the practice environment were analyzed at both types of organizations with the *t*-test. A Mann-Whitney U test was performed when the assumptions were not met for the *t*-test. These tests were performed when evaluating statistical significance in structural empowerment, the practice environment, and job satisfaction. Also, a Mann-Whitney U test was performed on job satisfaction levels and empowerment levels instead of an ANOVA (analysis of variance) test since only one total score was used for this measurement.

A two-way ANOVA test was performed when looking at structural empowerment's influence on education, job classification based upon work status, intent to stay, job satisfaction, self-reported medication error, and perception of quality of care of nurses working in both types of organizations. Education was categorized into two groups, those with baccalaureate or higher degree and those with a nursing degree below a baccalaureate level. Work status was categorized into two groups, those who work full time and those who don't. Job satisfaction was evaluated by summing the intrinsic,

extrinsic, and total scores. When examining perceptions about medication errors, two categories were defined as frequently and no frequently. When examining the perception about quality of care during the current shift and past shift, two categories were defined as excellent and those not excellent. Quality of care during the past year was categorized into two groups, improved and not improved. As for patients taking care of self once discharged, the two groups categorized included very confident and not very confident. Two-way ANOVA allows testing of the relationship of two categorical independent variables, and the two-way ANOVA analyzes the relationship between two variables affecting the outcomes of the dependent variable (Polit & Beck, 2012).

When examining age and empowerment levels in Magnet and non-Magnet organizations, a two-way ANCOVA (analysis of covariance) was performed. A two-way ANCOVA analysis was used to examine the relationship between a continuous variable affecting the outcomes of the dependent variable (Polit & Beck, 2012). When performing the analysis of empowerment and age, a scatterplot was conducted to see if empowerment levels increase as age increases. ANOVA or regression statistics was performed to look at age, empowerment level, and facility type.

### **Data Analyses for Specific Aims and Research Questions**

The specific aims along with the associated research questions and hypotheses for this study were:

1. Assess the structural empowerment level of acute care nurses, the practice environment, and hospital traits in Magnet and non- Magnet affiliated hospitals.

Research Question (RQ) 1: What is the level of structural empowerment of acute care nurses in Magnet and non- Magnet hospitals?

- Hypothesis (H) 1: Acute care nurses have higher levels of structural empowerment in Magnet affiliated hospitals when compared to non- Magnet affiliated hospitals.
- RQ 2: What is the level of the practice environment of acute care nurses in Magnet and non- Magnet hospitals?
- H 2: Acute care nurses working in Magnet organizations score higher on the practice environment scale in comparison to nurses working in non- Magnet affiliated facilities.

Descriptive statistics (frequencies, percentages, means, and standard deviations) along with a 95% confidence interval was used to address RQ 1 and RQ<sub>2</sub>. T-tests or Mann-Whitney U tests were performed on H 1 and H 2.

2. Examine the relationships among demographic variables (age, education, approximate hours worked per week) and empowerment level of nurses working in Magnet and non- Magnet affiliated hospitals.
  - H 3: Nurses with baccalaureate or higher nursing degrees have higher levels of empowerment in Magnet affiliated hospitals when compared to non- Magnet affiliated hospitals.
  - H 4: As age increases, nurses have higher levels of empowerment in Magnet affiliated hospitals when compared to non- Magnet affiliated hospitals.

- H 5: Acute care nurses who work full time have higher levels of empowerment in Magnet affiliated hospitals when compared to non- Magnet affiliated hospitals.

H 3 will have a scatterplot conducted with ANOVA statistics being performed. Two-way ANOVA tests were performed on H 2 and H 4. Two-way ANCOVA test was performed on H 4.

3. Examine the influence of empowerment on intent to stay and job satisfaction in Magnet and non- Magnet hospitals.

- RQ 3: What is the intent to stay level of acute care nurses in Magnet and non- Magnet hospitals?
- H 6: Nurses with high empowerment levels will have higher intent to stay levels in their current position in Magnet affiliated hospitals when compared to non- Magnet affiliated hospitals.
- RQ 4: What is the level of job satisfaction of acute care nurses in Magnet and non- Magnet hospitals?
- H 7: Nurses working in Magnet affiliated hospitals report higher levels of job satisfaction when compared to non- Magnet affiliated hospitals.
- H 8: Nurses with high empowerment levels are more likely to have higher satisfaction levels in Magnet affiliated hospitals when compared to non- Magnet affiliated hospitals.

Descriptive statistics (frequencies, percentages, means, and standard deviations) along with a 95% confidence interval was used to address RQ 3 and RQ 4. Two-way

ANOVA tests were performed on H 6 and possibly H 8. T-tests or Mann-Whitney U tests were performed on H 7.

4. Examine the impact of empowerment level with quality outcomes (medication errors and quality of care) reported by acute care nurses in Magnet and non- Magnet affiliated hospitals.
  - RQ 5: What is the rate of making a medication error (self-reported) with Magnet and non- Magnet facilities reported by acute care nurses?
  - H 9: Nurses with high empowerment levels are less likely to make a medication error in Magnet affiliated hospitals when compared to non- Magnet affiliated hospitals.
  - RQ 6: What is the quality of care (self-reported) with Magnet and non- Magnet facilities reported by acute care nurses?
  - H 10: Nurses with high empowerment levels are more to report higher quality of care in Magnet affiliated hospitals when compared to non- Magnet affiliated hospitals.

Descriptive statistics (frequencies, percentages, means, and standard deviations) along with a 95% confidence interval was used to address RQ 5 and RQ 6. A test of interaction from logistic regression will be performed on H 9 and H 10.

### **Summary**

The purpose of this cross-sectional study was to examine structural empowerment's influence on various nursing outcomes in Magnet and non- Magnet organizations. The study examined the influence of structural empowerment on

individual factors such as demographics, job satisfaction, and intent to stay as well as on organizational factors such as the practice environment, quality of care, and medication errors. The study evaluated if acute care nurses consider themselves in the work environment while also comparing this concept in organizations that were Magnet and non-Magnet.

CHAPTER IV  
THE PRACTICE ENVIRONMENT COMPARED BETWEEN MAGNET  
AND NON-MAGNET ORGANIZATIONS

**Introduction**

The American Nurses Credentialing Center's (ANCC) Magnet™ recognition program is the marker of distinction for hospitals when discussing excellence in care. Accompanying this designation is the feeling of an entitlement of superiority in hospital patient care outcomes and measurements as this designation is considered the pinnacle of all designations in healthcare throughout the United States (Kooker & Kamikawa, 2009). Since Magnet's inception in the 1980's, ANCC has promoted and encouraged this designation to be achieved by hospitals. Initially, Magnet was linked to recruiting and retaining nurses in order to provide superb care (Aiken, Buchan, Ball, & Rafferty, 2008; Flynn & McCarthy, 2008; Joyce & Crooks, 2007). In the early 1990's, ANCC identified Magnet hospitals as those organizations that promoted nursing excellence through work environments which promoted improved outcomes, increased job satisfaction, and reduced turnover (Caldwell, Roby-Williams, Rush, & Ricke-Kiely, 2009; Kramer, Maguire, & Brewer, 2011; McHugh & Stimpfel, 2012; Rodwell & Demir, 2013; Tuazon, 2007). Being designated as a Magnet organization provides hospitals with a robust nursing culture as hospitals strive to be the best. In 2010, approximately 7% of hospitals

had Magnet status (Lake, Shang, Klaus, & Dunton, 2010). Finally, Bennett et al. (2012) reported that a substantial variation in perceptions about professional nursing governance as Magnet hospitals scored higher than non-Magnet facilities when researched.

Currently, ANCC claims that the benefits of Magnet designation include attracting and retaining top talent, improving patient care, safety, and satisfaction, and fostering a collaborative culture (retrieved on 9/14/4 from <http://www.nursecredentialing.org/Magnet/ProgramOverview>). However, is the practice environment different in Magnet hospitals when compared to non-Magnet organizations?

Multiple outcomes have been evaluated when looking at Magnet organizations in comparison to other types of facilities. Empowered work environments have demonstrated lower levels of burnout and higher levels of satisfaction (Laschinger, Almost, & Tuer-Hodes, 2003). Performance and productivity have strongly been correlated with positive outcomes (Tuazon, 2007). As the practice environment may differ from one healthcare organization to another, comparing the work environments in both Magnet and non-Magnet organizations is the purpose of this research.

### **Magnet Organizations**

Magnet is a designation that the ANCC has provided to healthcare organizations that have elected to put excellence forthright in patient care. Accompanying this designation is the feeling of superiority in hospital patient care outcomes (Kooker & Kamikawa, 2009). With the largest healthcare profession representing over 2.5 million nurses in the workforce (Ericksen, 2009; Rodwell & Demir, 2013), outcomes from organizations need to be distinct and attractive to the customers involved in the

healthcare industry. Magnet believes that empirical outcomes can be achieved in hospitals that practice in four domains. These domains are structural empowerment, exemplary professional practice, transformational leadership, and new knowledge, innovation, and improvements (Grant et al., 2010). As Magnet facilities are linked to superior outcomes, does this status of being Magnet alone provide a better work environment for nurses?

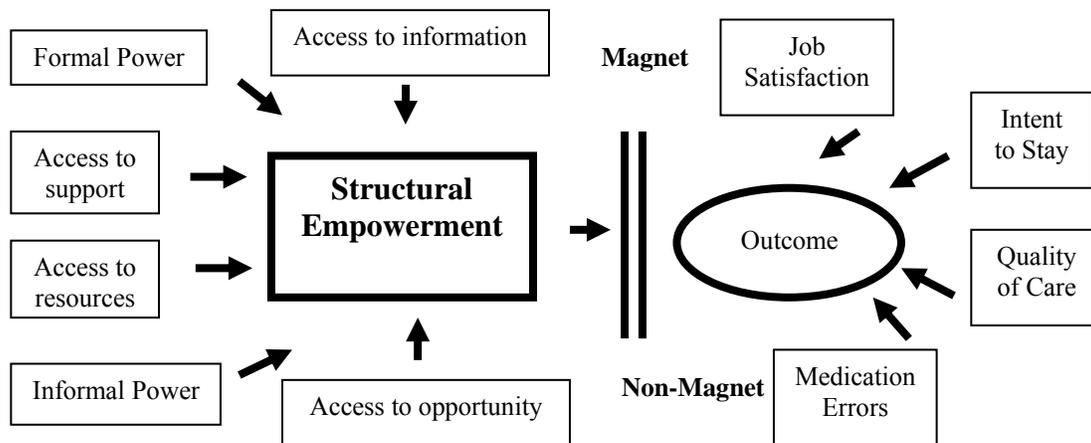
### **Purpose**

The purpose of this study was to examine the practice environments in both Magnet and non-Magnet organizations. This study explored the practice environment in both types of healthcare organizations.

### **Conceptual Model**

As empowerment's definition is identified, Kanter's structural empowerment becomes the primary empowerment theory within the workplace. Kanter, renowned for her theory within the business sector, provides insight about empowerment and organizational commitment (Kanter, 1977). Kanter's structural empowerment theory provides the foundational work for many nurse scientists as her theory involves managers taking specific actions to create high quality work environments that foster trust and enhance work effectiveness (Kanter, 1977; Laschinger, Leiter, Day, & Gilin, 2012; Stein & Kanter, 1980). Kanter's theory imparts a foundational premise in which motivated employees seek a committed work relationship (Laschinger, Wong, & Greco, 2006). The four components contributing to this healthy work relationship include access to support, resources, information, and opportunity with formal and informal power being essential

to this phenomenon (Cowden & Cummings, 2012; Laschinger et al., 2012; Laschinger, Wilk, Cho, & Greco, 2009; McDonald, Tullai-McGuinness, Madigan, & Shively, 2010; Stein & Kanter, 1980). Kanter hypothesizes that access to these factors contribute to professional growth and organizational goal achievement (Kanter, 1977; Laschinger & Havens, 1996; Stein & Kanter, 1980). Also, formal and informal powers are imperative to this theory and assist with accomplishing goals for the organization (Chambers & Thompson, 2008). Formal power is defined by how nurses perceive their job role in terms of flexibility, visibility, and importance of the job in terms of creativity and innovation whereas informal power provides the nurse with the opportunity to establish networks with peers, sponsors, and subordinates (Davies, Laschinger, & Andrusyszyn, 2006; McDonald et al., 2010). By having the four structural components along with both types of power, the nurse can become empowered within the work setting which allows organizational goals to be accomplished (see Figure 2).



*Figure 2. Conceptual Framework Based on Kanter's Structural Empowerment*

Kanter's Structural Empowerment Theory is the most popular theory researched and discussed throughout the literature. This theory has been referenced in many research studies as specific outcomes and measures have been linked to this framework as indicated by many studies (Castro, Periñan, & Bueno, 2008; Hauck, Griffin, & Fitzpatrick, 2011; Krapohl, Manojlovich, Redman & Zhang, 2010; Wong & Laschinger, 2013; Yang, Liu, Huang, & Zhu, 2013; Young-Ritchie, Laschinger, & Wong, 2009). Kanter, renowned for her theory within the business sector, provides insight about empowerment and organizational commitment (Kanter, 1977). Kanter's structural empowerment theory provides the foundational work for many nurse scientists as this theory involves managers, leaders, and administrators taking specific actions to create high quality work environments that foster trust and enhance work effectiveness (Kanter, 1977; Laschinger et al., 2012; Stein & Kanter, 1980). In this theory, work behaviors are

created in response to the composition of the work environment and not due to the characteristics of the individual (Laschinger, Sabiston, & Kutzscher, 1997; Ridley, Wilson, Harwood, & Laschinger, 2009). This theory of structural empowerment in organizations provides a useful theoretical framework when examining the nursing work environment and the ways nurses respond to their work experiences and environment.

Stein and Kanter (1980) maintained originally that key aspects of the structural empowerment theory involved individual effectiveness, behaviors, motivation to perform, and opportunities. Behaviors included opportunities to advance and ability to utilize resources so that organizations would be able to react appropriately (Stein & Kanter, 1980). According to Kanter, when the organization provides structural components, employees are more effective on the job and feel good about the tasks that they are doing (Manojlovich & Laschinger, 2007). A sense of team between the employee and employer is produced. Results can be seen through patient and staff outcomes. Control over work conditions has been linked to work effectiveness (Hauck et al., 2011; Laschinger et al., 1997). Kanter believed that employees want to be involved within the workplace. When employees are faced with work obstacles such as lack of growth and development, they will become disengaged and seek satisfaction in other places. Employees want opportunities to learn, enjoy, socialize, and express themselves with challenging jobs; however, employees will look elsewhere if they become frustrated (Kanter, 1979).

Kanter's Structural Empowerment Theory involves focusing on the organization and the work environment instead of the individual. This theory imparts the foundational

premises that an individual must have access to structural components in order for the business to thrive. These components include support, resources, information, and opportunity. As these structural determinants are provided in the organization, the organization becomes successful because the employees are more satisfied and committed to the goals of the company due to the components that they have that support their role. The individual develops a mentality that their work is meaningful. This theory has been used to link the concept of empowerment to several measurements such as burnout, engagement, incivility, intent to stay, job satisfaction, job tension, organizational trust, productivity, retention, work effectiveness, work quality (Cowden & Cummings, 2012; Hochwalder, 2008; Laschinger, 2008; Lee & Cummings, 2008; McDonald et al., 2010; Stein & Kanter, 1980; Young-Ritchie et al., 2009). It is important to have structural empowerment in the workforce as companies not only want to be successful, but they want their employees to be satisfied. There can be overlap with psychological empowerment, but this type of theory focuses mainly on establishing the healthy work environment.

Kanter's Structural Empowerment Theory includes empowerment being developed within the organization and not just with the individual. Even though the individual is a key component about the success of the company, this type of empowerment focuses on the components that make the organization successful. The structural components are established to assist in the work environment of the entire company, not just on the individual. The literature shows how important these components are for maintaining a healthy work environment unlike psychology

empowerment where the focus is on the individual. Structural empowerment entails a process that focuses on the employee being productive and satisfied within the organization.

### **Constructs of Structural Empowerment**

The structural components of Kanter's organizational empowerment include accessing opportunities, receiving support, mobilizing resources, and accessing information. Access to opportunity implies that the employee is provided more learning, challenges, knowledge, and skills for professional growth and advancement (Laschinger, Leiter et al., 2009; Laschinger et al., 1997; Sabiston & Laschinger, 1995; Yang et al., 2013). This factor provides the employee with the opportunity to gain a new skill or to be recognized for efforts (Tigert & Laschinger, 2004). Opportunities involve those responsibilities beyond one job's description (Manojlovich, 2007) and may exist in the form of a job promotion or creation of new job skill. With nurses feeling empowered and the structural components being provided to them, these nurses will establish more confidence in the organization as opportunities persist. Commitment to the organization can be established because the nurse has been provided empowerment in the work place.

When feedback is received by others, it means that the employee has received support (Yang et al., 2013). Receiving direction and counsel from supervisors, peers, or subordinates as well as obtaining emotional support, helpful advice, or hands-on experience provides the support that is needed for an employee to be effective in the work environment (Laschinger, Leiter et al., 2009; Tigert & Laschinger, 2004). Support allows the individual to feel that the organization has their back. An empowered nurse

wants the support that the company is there for them. This will create trust between the employee and employer which leads to satisfaction in the workplace.

Access to resources implies that money, materials, supplies, time and equipment are acquired to accomplish goals (Laschinger, Leiter et al., 2009; Sabiston & Laschinger, 1995; Tigert & Laschinger, 2004; Yang et al., 2013). Having necessary equipment and supplies to complete the job will always benefit the organization. Organizations want individuals to be productive. The only way that productivity can occur is that the necessary supplies are available.

Access to information denotes having the chance to learn organizational decisions, policies, and data as well as goals (Yang et al., 2013). Information allows the individual to execute tasks to perform one's job (Tigert & Laschinger, 2004).

Laschinger, Leiter, Day and Gilin (2009) emphasize that information involves having knowledge of organizational decisions, policies, and goals as well as technical knowledge and expertise in order to be effective. By being informed, the employee feels that the company has trust in them.

With these four components of structural empowerment according to Kanter, the nurse will feel valued in the organization. This value will lead to a healthy environment because the employee will be satisfied. When components are stripped away such as supplies or resources, the individual will feel less empowered as their work suffers. Having necessary structural determinants will always benefit the company and will make the employee feel like they are contributing to the organization's goals.

Power is the ability of getting employees to get things done (Sabiston & Laschinger, 1995). Formal power is defined by how nurses perceive their job role in terms of flexibility, visibility, and importance of the job in terms of creativity and innovation (Davies et al., 2006; Laschinger et al., 1997; McDonald et al., 2010; Tigert & Laschinger, 2004; Yang et al., 2013). Visibility in the organization is important especially when decisions are being made. Informal power provides the nurse with the opportunity to establish networks and alliances with peers, sponsors, and subordinates so that work can be accomplished (Davies et al., 2006; Laschinger et al., 1997; McDonald et al., 2010; Sabiston & Laschinger, 1995; Tigert & Laschinger, 2004; Yang et al., 2013). Employees that depend upon power are prone to accomplish their work in a meaningful way.

Access to structural empowerment components result in increased motivation, autonomy, employee decisional involvement, organizational commitment, and job satisfaction. Consequently, employees become more productive and effective in meeting organizational goals (Tigert & Laschinger, 2004). Kanter's theory provides a fundamental incentive for employees as advancement in knowledge and skills not only benefit the employee, but it also will benefit the organization. When employees are provided an environment that supports empowerment, work productivity becomes improved and increased. The employee will be more satisfied and committed to their work with less likelihood of feeling burnout. This feeling also will provide for better quality of care. As the structural components are provided in the workplace, the worker takes more pride in accomplishing meaningful work (Yang et al., 2013). If an employee

lacks these structures, then they may feel disempowered which may contribute to burnout and mistakes in the job setting. Allowing nurses flexibility to use their knowledge to problem solve promotes more autonomous practice which creates a better working environment for the employee (Laschinger et al., 1997). If the structures exist, the nurse is more apt to be committed and motivated within the organization. This results in the nurse being autonomous and more involved in the decision-making process which overall affects the organization (Sabiston & Laschinger, 1995; Young-Ritchie et al., 2009). In other words, the nurse is able to accomplish more at work.

### **Conceptual Definitions**

1. Structural empowerment. Structural empowerment is defined as having the essential work structures (access to information, opportunity, resources, and support) that empower individuals to accomplish their work in a meaningful way (Laschinger, 2008).
2. Information. Access to information is defined by the individual having the knowledge of organizational policies and goals as well as access to the data and expertise to be efficient in the work environment (Kanter, 1977).
3. Opportunity. Access to opportunity is defined as having the potentiality for growth as challenges and rewards contribute to improved knowledge and skills (Kanter, 1977).
4. Resource. Access to resources is defined as having the ability to access materials, money, supplies, time, and equipment in order to achieve organizational goals (Kanter, 1977).

5. Support. Access to support is defined as having constructive feedback and guidance from work colleagues (Kanter, 1977).
6. Formal power. Formal power is augmented when jobs are adaptable and allows for employees to exercise ingenuity in decision-making (Ning, Zhong, Libo, & Qiujie, 2009).
7. Informal power. Informal power is derived from the development of successful relationships and communication with colleagues inside and outside the organization (Ning et al., 2009).
8. Magnet hospitals. Magnet Hospitals are those organizations designated through the ANCC that promote nursing excellence through excellent outcomes and work environments (Kramer, Maguire, & Brewer, 2009; McHugh & Stimpfel, 2012).

### **Aims and Research Questions**

The specific aim along with the associated research questions and hypotheses for this study was:

- 1) Assess the structural empowerment level of acute care nurses and the practice environment in Magnet and non-Magnet affiliated hospitals.

Research Question (RQ) 1: What is the level of structural empowerment of acute care nurses in Magnet and non-Magnet hospitals?

Hypothesis (H) 1: Acute care nurses have higher levels of structural empowerment in Magnet affiliated hospitals when compared to non-Magnet affiliated hospitals.

RQ 2: What is the level of the practice environment of acute care nurses in Magnet and non-Magnet hospitals?

H 2: Acute care nurses working in Magnet organizations score higher on the practice environment scale in comparison to nurses working in non-Magnet affiliated facilities.

### **Review of Literature**

The review of literature extends over the last two decades as this concept has been studied and measured with a variety of outcomes. The electronic databases Cumulative Index to Nursing and Allied Health (CINAHL), Journal Storage (JSTOR), Psychological Information (Psycinfo), Medlars On-line System (Medline), and Public Medline (PUBMED) were searched. Searches were limited to researches that were available in the English language and peer-reviewed journals. Search terms used included “burnout”, “burnout and nursing”, “empowerment”, “empowerment and nursing”, “empowerment and outcomes”, “engagement”, “engagement and empowerment”, “engagement and nursing”, “hospital reimbursement and quality”, “intent to stay”, “intent to stay and nursing”, “job satisfaction”, “job satisfaction and empowerment”, “job satisfaction and engagement”, “job satisfaction and nursing”, “Magnet”, “Magnet and non-Magnet hospitals”, “Magnet hospitals”, “Magnet outcomes”, “nurse, empower, and employment”, “satisfaction, reimbursement, and hospital”, and “work engagement”. Additional articles were located on EBSCO data base or Google Scholar that examined the terms “empowerment and nursing”, “job satisfaction and nursing”, and “intent to stay and nursing”. More than 175 articles were reviewed. This review of literature about the state

of science related to empowerment included articles from other professions and disciplines that could be influential to the outcomes related to this concept. The review of literature also included articles that looked at healthcare workers and the outcomes desired for this research.

Laschinger, Wong, and Greco (2006) performed a cross-sectional correlational study with randomized sample of 322 staff nurses in acute care hospitals in Ontario. These authors tested Kanter's organizational empowerment theory and Maslach and Leiter's work engagement model. Nurses rated total empowerment as being moderate ( $M = 18.43$ ;  $SD = 3.41$ ). Nurses rated access to opportunity as being the greatest ( $M = 3.98$ ;  $SD = 0.81$ ) and formal power as being the least empowering factor ( $M = 2.49$ ;  $SD = 0.85$ ). Nurses reported high levels of burnout ( $M = 3.17$ ;  $SD = 1.50$ ) (Laschinger et al., 2006).

Laschinger and Wong (1999) performed a cross-section correlational study using Kanter's theory. Their study tested the relationship between formal power, informal power, and access to empowerment structures in a large academic medical center in Canada. A sample size of 647 registered nurses was used for this research study. Results indicated that nurses perceived their work environment moderately empowering ( $M = 10.91$ ;  $SD = 1.96$ ). Nurses rated access to opportunity as being the greatest ( $M = 2.86$ ;  $SD = 0.56$ ) and access to information being the least empowering factor ( $M = 2.64$ ;  $SD = 0.65$ ). Formal power was not rated high ( $M = 2.64$ ;  $SD = 0.65$ ), but nurses did perceive that they did have informal power ( $M = 3.25$ ;  $SD = 0.59$ ). Structural equation modeling showed that productivity (the work effectiveness indicator) revealed a good fit with the

data ( $\chi^2 = 52.014$ , GIF = 0.970, AGFI = 0.90). Results showed that informal power influenced accountability through access to all empowerment structures according to Kanter (Laschinger & Wong, 1999).

Laschinger et al. (2012) performed a quasi-experimental design. This study examined the impact of a workplace intervention on nurses' empowerment, experiences of supervisor and coworker incivility, and trust in nursing management. The study compared intervention units in Nova Scotia and Ontario, and data was collected through the use of a questionnaire. The sample was limited to registered nurses, and data was collected at two times (Time 1,  $n = 755$ ; Time 2,  $n = 573$ ). Eight units participated in the intervention whereas 33 units were in the controlled group. Data were collected initially and then after a 6-month intervention time period. Hierarchical linear modeling was used to test the impact of the intervention. Results showed that total empowerment was correlated with trust in management (T1:  $r = 0.41$ ; T2:  $r = 0.45$ ), supervisor incivility (T1:  $r = 0.23$ ; T2:  $r = 0.25$ ), and coworker incivility (T1:  $r = 0.11$ ; T2:  $r = 0.16$ ). There were significant time-by-group interaction effects for four outcome variables: access to the support empowerment structure ( $\beta = 0.39$ ,  $p < 0.001$ ), the resources empowerment structure ( $\beta = 0.18$ ,  $p = 0.03$ ), trust in management ( $\beta = 0.03$ ,  $p = 0.007$ ), and supervisor incivility ( $\beta = -0.06$ ,  $p = 0.005$ ). The cross-level interaction for total empowerment was significant ( $\beta = 0.14$ ,  $p = 0.057$ , two-tailed). Results showed that improvements over time for support, resources, total empowerment, trust in management, and supervisor incivility variables were larger for the intervention group ( $R^2$  values from 0.02 to 0.05).

when compared with the control group ( $R^2$  values from 0.00 to 0.01) (Laschinger et al., 2012).

As behaviors and outcomes are identified and cyclical, creation of a healthy work environment occurs (Laschinger, Leiter et al., 2009). Laschinger, Leiter et al. (2009) examined the influence of an empowering work conditions and workplace incivility on nurses' experiences of burnout and retention. Three retention outcomes were measured in 612 Canadian nurses. These included job satisfaction, organizational commitment, and turnover intentions. Results from hierarchical multiple regression analyses showed that empowerment, workplace incivility, and burnout explained statistical significance in the three retention factors of job satisfaction ( $R^2 = 0.46$ ), organizational commitment ( $R^2 = 0.29$ ), and turnover intentions ( $R^2 = 0.28$ ). Empowerment, supervisor incivility, and cynicism most strongly predicted job satisfaction whereas emotional exhaustion, cynicism, and supervisor incivility most strongly predicted turnover intentions (Laschinger, Leiter et al., 2009).

### **Empowerment and the Work Environment in Magnet Organizations**

Faulkner and Laschinger (2008) showed that empowered nurses who feel more respected in the work environment will be satisfied and committed especially if the traits of autonomy, confidence, meaningfulness and a feeling of being able to have an impact in the organization are promoted. These authors examined the relationship between structural and psychological empowerment and their effects on hospital nurses' perceptions and respect from a Canadian province. The sample included 282 nurses. Findings supported Kanter's theory which emphasized that nurses perceive themselves to

be empowered and are more likely to feel respected in the work environment. Nurses reported being moderately empowered ( $M = 17.8$ ,  $SD = 3.3$ ). Nurses did report opportunity as the greatest empowering structure ( $M = 4.0$ ,  $SD = 0.79$ ). Other results included nurses reporting a sense of meaning at work ( $M = 4.2$ ,  $SD = 0.76$ ) but feeling that they made no significant impact in the organization ( $M = 2.5$ ,  $SD = 0.97$ ). Structural empowerment was significantly and positively related to perceived respect ( $r = 0.47$ ,  $p < 0.001$ ) as well as each of the structural empowerment factors (Faulkner & Laschinger, 2008).

When comparing different organizations, Laschinger, Almost, and Tuer-Hodes (2003) did a secondary analysis of three previous research studies conducted. Two studies involved staff nurses and one study involved nurse practitioners. The setting was in Canada. These authors reported about nurses' perceptions of workplace empowerment, Magnet characteristic, and job satisfaction in different work settings and showed how relationships between structural empowerment and Magnet organization characteristics were significant. Autonomy, control over practice, and positive nurse-physician relationships were shown to be significant with structural empowerment. Results were very similar to previous work conducted by Aiken in 2000. However, access to information ranked high to the overall work environment indexes ( $r = 0.52$ ). Empowerment and Magnet hospital characteristics were significant predictors of job satisfaction ( $R^2 = 0.502$ ,  $F = 26.25$ ,  $df = 2.52$ ,  $p < 0.001$ ). Their results indicated that empowered work environments support professional practice as nurses in Magnet

facilities reported lower levels of burnout and higher levels of job satisfaction (Laschinger et al., 2003).

Kramer and Schmalenberg (2004a) examined what Magnet hospital nurses meant by each of the essentials of Magnet, what it meant to practice autonomously, and what was meant by a good working relationship with physicians. These authors showed higher results for Magnet affiliated facilities over Magnet aspiring and other facilities when evaluating the support of education. The value of education, availability of school programs, and financial assistance were reported to be higher in Magnet organizations. However, fewer rewards were considered lower in Magnet facilities. When evaluating working with nurses who are viewed clinically competent, Magnet hospital nurses reported higher scores for overall rating of competency, support of specialty certifications, preference of baccalaureate degree, and hospital reward of competency. However, peers reinforcement of one another for high quality of care was reported to be lower in Magnet hospital nurses. Finally, Magnet hospital nurses reported more positively with nurse and physician relationships in the following areas: collegial, collaborative, student-teacher with the physician being the teacher, and student-teacher with the nurse being the teacher (Kramer & Schmalenberg, 2004a).

Kramer and Schmalenberg (2004b) also found that acute care nurses in Magnet hospitals reported nurses as being more autonomous and competent in their decision-making in comparison to non-Magnet hospital nurses. In this study, autonomy was defined as being the freedom to act on choices in practice which are of best interest of the parties involved. Nurses reported higher scores for autonomy when examining

accountability. Nurses rated lower scores when permission was needed first, rules inhibit decisions, and environment was too risky (Kramer & Schmalenberg, 2004b).

Tuazon (2007) discussed where evidence demonstrates positive outcomes related to Magnet affiliated facilities that allow nurses to be more autonomous and promote decision-making in practice as results showed improved patient satisfaction, enhanced physician satisfaction, and an increase in operating margin from 4% to 16% as Magnet hospitals outperformed non- Magnet hospitals. In a systematic review, Wagner et al. (2010) reported that structural empowerment, which is a component emphasized in Magnet recognition, demonstrated in health care settings supports healthier employees, reduces stress, and increases employee commitment to organizational goals, which overall culminates in improved organizational outcomes including improved patient outcomes. Ten articles were examined that represented six studies. These studies revealed associations between structural empowerment and psychological empowerment in registered nurses. This review concluded that having structural empowerment components contributed to a strong workforce and led to higher satisfaction scores and higher retention of nurses.

Hader, Saver, and Steltzer (2006) showed data where Magnet facilities provide more services and benefits when compared to other facilities. In a sample of 978 participants, surveys were distributed to collect data about the workforce. Data revealed that with each year, more nurses plan to retire and more plan to be leaving the profession on an annual basis. Providing these benefits contribute to lower turnover and greater job satisfaction. In general, it was reported that Magnet hospitals provide more support for

nurses when compared to other facilities. It was also noted that Magnet organizations provided wellness programs for staff where other organizations did not. Clinical ladders were more popular in Magnet organizations (Hader, Saver, & Steltzer, 2006).

Caldwell, Roby-Williams, Rush, and Ricke-Kiely (2009) tested a hypothesis associated with readiness. These authors reported that Magnet organizations provide higher quality of care, but little research is known about nurses' attitudes and behaviors in Magnet organizations. In a sample of 306 registered nurses, these authors investigated factors that influenced the willingness to embrace change needed with a Magnet affiliated status. Hierarchical linear modeling was used for statistical analysis. Results revealed that nurses are more attracted to Magnet hospitals as these facilities allow nurses to learn and excel in their skills (Caldwell et al. 2009).

Finally, Laschinger, Wong, Grau, Read, and Stam (2011) reported that empowered nurses are more likely to remain in their current nursing positions and remain committed to the achieving quality patient outcomes. Creating an environment where nurses are respected and listened to will promote job satisfaction and retain nurses while also allowing for better patient outcomes. The environment becomes magnetic in attracting the right clientele to work. A positive working environment for nursing staff is essential when desiring improved quality of patient care, and this is why the American Nurses Credentialing Center (ANCC) attributes greater safety and quality in Magnet organizations. The question posed is whether or not Magnet organizations are superior in these outcomes when compared to other organizations.

## **Methodology**

### **Design**

This research utilized a correlational, cross-sectional design to assess the relationship between structural empowerment and the practice environment respectively in Magnet and non-Magnet affiliated hospitals. A cross-sectional design allowed data to be collected only once during a single period. An online survey was distributed to eligible nurse participants that work in both types of hospitals, Magnet and non-Magnet over a period of one month in a specific region of the United States.

### **Sample**

The target population was nurses working at organizations that were either Magnet affiliated or non-Magnet affiliated. One organization was comprised of 14 hospitals that were located throughout North Carolina and Virginia. Another organization had six hospitals located in the central part of the state of North Carolina. One other non-Magnet rural and community based facility was included in this research. A total of 21 hospitals were used to recruit participants. All of these facilities were purposely selected as representative of Magnet and non-Magnet organizations. All of the healthcare organizations participating in this research were not for profit. The organizations invited to participate were chosen due to the proximity of the investigator's location and employment affecting approximately 6500 nurses. All nurses, including leaders as well as staff nurses, were eligible for this study. All nurses at these organizations received an invitation to participate in the research via the healthcare system's electronic email.

## **Methods**

The researcher met with the nursing research councils of the two major organizations and corresponded electronically and via telephonic to the one smaller rural facility. The meetings were conducted to obtain permission to conduct the research at their respective institutions or organizations. Nurse participants were recruited through the healthcare system's electronic mail system. An email was sent to all nurses working for the specific market of the organizations chosen. The email contained an electronic letter explaining the purpose and importance of the study. A survey link was embedded within the email which directed them to an independent website for data collection. Access to the link was available through any computer that had internet access. The survey was available for approximately four weeks for data collection. All nurses completing the survey within the allotted time frame were included. All consents were provided and submitted electronically with the submission of the survey. Only an electronic survey was used to collect data, and Qualtrics<sup>TM</sup> was the electronic instrument used for data collection. No paper surveys were collected. Nurse participants completed the survey at their convenience. Completed surveys were examined only by the investigator, research assistant, and statistician or consultant and were kept electronically. Password access to the computer data was required for security purposes. To assure anonymity, no identification codes were linked to any completed electronic surveys.

After analyzing the research questions and study hypotheses, it was determined that five hypotheses required the largest sample size for adequate statistical power to detect an association between empowerment subscales and the measure being evaluated.

A medium effect size of Cohen's  $f^2 = 0.25$  between structural empowerment level and the other measures was detected with a 2-way logistic regression with at least 80% power when the sample size was 209 nurses, assuming a two-tailed type I error = 0.00625 (i.e., 0.05/8 for the eight types of job satisfaction) and adjusting for gender, race/ethnicity, age, years in nursing, years in current nursing position, years in nursing, education level, length of shift, professional job role, typical shift worked, and average hours worked per week.

### **Human Subject Protection**

An Institutional Review Board (IRB) application was submitted for approval to the University of North Carolina at Greensboro (UNCG) IRB as well as each of the organization's IRB where the study occurred. If a facility did not have an IRB, a letter of permission was obtained by the nursing director at the facility and submitted to UNCG.

### **Instruments**

Three instruments were used for data collection: (a) a researcher designed demographic and information form, (b) Conditions of Work Effectiveness– II (CWEQ-II), and (c) Practice Environment Scale (PES). Demographic information was obtained first with demographics including age, gender, race, years in the nursing and in the role, education, and job characteristics. Question related to structural empowerment were next and followed by questions about the practice environment.

Two instruments (Conditions of Work Effectiveness – II and Practice Environment Scale) required scores to be calculated for this research. Scoring was calculated according to recommendations of the instrument authors. To check for

internal consistency, Cronbach's alpha coefficient was estimated for each instrument. Cronbach's alpha is a measure of the reliability of the instrument. The higher the coefficient means the greater the reliability (Polit & Beck, 2012). Cronbach's alpha should be above 0.70 which indicates that items in the scale are internally consistent (Nunnally & Bernstein, 1994). The instruments had coefficients for total scores ranging from 0.87 to 0.93. Tables 3 and 4 details estimated Cronbach's alphas for each of the instruments.

### **Demographic Information Form**

The demographic information form was developed for this study to obtain characteristics about the nurse participants. The individual information collected included the participant's place of employment, gender, race, age, number of years in nursing, number of years in current nursing role, number of years on the nursing unit, number of hours worked in a typical week, length of shift worked, shift of work, work status, primary unit of employment, job role, and education. Also, the individual was asked if their organization was on the pathway for excellence for Magnet. These measures were selected from a review of the literature on structural empowerment and Magnet organizations (Kramer et al., 2011; McDonald et al., 2010; Ning, Zhong, Libo, & Qiujie, 2009; Ridley et al., 2009; Tigert & Laschinger, 2004).

### **Conditions of Work Effectiveness – II (CWEQ-II)**

Structural empowerment was measured by the CWEQ-II. The questionnaire consists of 19 items, composed of six subscales, and uses a 5-point Likert scale that ranges from none to a lot. The subscales include access to information, resource,

opportunity, and support as well as formal and informal power. Scores are determined by summing items, with high scores representing high levels of the construct. Laschinger, Finegan, Shamian, & Wilk (2001) validated the factor structure of CWEQ-II and recommended creating a total score by summing the six subscales with the scores ranging from 6 to 30. Various research studies have reported that the Cronbach alpha for reliability for the different components of structural empowerment ranged from 0.68 to 0.93 (Armstrong & Laschinger, 2006; Ellefsen & Hamilton, 2000; Faulkner & Laschinger, 2008; Hauck et al., 2011; Krapohl et al., 2010; Laschinger, 2008; Laschinger et al., 2003; Laschinger, Wong, Grau, Read, & Stam, 2011; Ning et al., 2009; Purdy, Laschinger, Finegan, Kerr, & Oliveria, 2010; Sabiston & Laschinger, 1995; Tigert & Laschinger, 2004).

### **Practice Environment Scale (PES)**

The practice environment was measured using Lake's PES of the Nursing Work Index. This instrument consists of 31 items that measure the six components of nursing participation, nursing foundation for care, management ability, adequate staff, and collaborative relationships (Armstrong & Laschinger, 2006). Cronbach alpha reliabilities range from 0.71 to 0.80 with subscales ranging from 0.65 to 0.84.

### **Data Analyses**

The data were verified and corrected when erroneous data was noted. The data were verified for missing information or questionable responses prior to further analysis. Patterns of missing data were examined to see if missing data adjustments were needed; however, no corrections were made due to missing data being dispersed and being less

than 5% (Polit & Beck, 2012). If a pattern of missing data was not random, a statistician was consulted to perform sensitivity analysis for the data that was missing (Polit & Beck, 2012).

Data were analyzed using SPSS 19.0 software (SPSS Inc., Chicago, IL). Descriptive statistics were used to describe the demographics of the population. Descriptive statistics were used to assess and compare empowerment levels of nurses at Magnet and non-Magnet organizations. Descriptive statistics were performed to assess for outliers. Assumptions of analyses were checked including normality, linearity, and homoscedasticity where appropriate. The data were examined to determine if they were theoretically out of range. A two-sided  $p$ -value  $< 0.05$  was considered statistically significant.

Comparisons of the two different groups, Magnet and non-Magnet, were conducted by performing independent  $t$ -tests. Structural empowerment and the practice environment were analyzed at both types of organizations with the  $t$ -test. A Mann-Whitney U test was performed when the assumptions were not met for the  $t$ -test. These tests were performed when evaluating statistical significance in structural empowerment and the practice environment.

## **Results**

### **Sample Demographics**

The sample consisted of 1405 nurses from twenty-one hospitals located in North Carolina and Virginia. There were 1003 nurses from Magnet and 402 nurses from non-Magnet hospitals who participated in this survey. Nurse participant ages ranged from 21

to 70 with the average age for Magnet nurses being 43.69 (SD = 11.8) and the average age for non-Magnet nurses being 43.76 (SD = 11.6). The majority of the sample was women (90.5%) with Magnet hospitals having 90.5% and non-Magnet hospitals having 90.3% of women. The majority of the sample worked day time hours (70.6%) with 70.2% of nurses in Magnet hospitals and 71.6% of nurses in non-Magnet hospitals. The average number of hours working in a given week for Magnet nurses was 36.8 (SD = 8.1) and for non-Magnet nurses was 37.4 (SD = 8.1). The majority of the sample worked full time (83.4%) with Magnet hospitals being 83.2% and non-Magnet hospitals being 84.1%.

Years in the nursing profession for nurse participants ranged from less than one year to 46 years with an average for Magnet nurses of 17.2 years (SD = 12.3) and for non-Magnet nurses equal to 16.8 years (SD = 11.9). Years in the nurses' current roles ranged from less than one year to 44 years with the average years in current role for Magnet nurses being 8 years (SD = 8.7) and the average years in current role for non-Magnet nurses being 8.5 years (SD = 9.1). The range of years working on the current unit varied from less than one year to 38 years with the average number of years working on the current unit in Magnet organizations being 6.7 years (SD = 7.4) and the average number of years working on the current unit in non-Magnet being 6.3 years (SD = 6.9).

A slight majority of nurse participants had baccalaureate or higher degrees (53.4%) with Magnet nurses having a baccalaureate or higher degree (56.5%) and non-Magnet nurses having a baccalaureate or higher degree (46.1%). The majority of the sample worked in clinical inpatient areas (58.9%) with Magnet nurses working in clinical inpatient areas (57.6%) and non-Magnet nurses working in clinical inpatient areas

(61.9%). The majority of the sample was staff nurses (77.8%) with Magnet staff nurses (76.7%) and non-Magnet staff nurses (80.6%). Tables 1 and 2 provide specific information regarding the demographics of the sample.

*Table 1*

*Overall Demographic Characteristics of the Study Sample (N = 1405)*

<b>Variable</b>	<b>Minimum</b>	<b>Maximum</b>	<b>N(%) or Mean ± SD</b>
Gender			
Female			1271 (90.5)
Male			84 ( 6.2)
Not indicated			50 ( 3.6)
Age	21	70	43.71 ± 11.8
Years in Profession	0	46	17.1 ± 12.2
Years in Current Role	0	44	8.1 ± 8.9
Years on Current Unit	0	38	6.6 ± 7.3
Hours worked in a week*			37.0 ± 8.1
Work Status			
Full time			1172 (83.4)
Part time			127 ( 9.0)
PRN			76 ( 5.4)
Not indicated			30 ( 2.1)
Shift worked			
Daytime (between 7a – 7p)			992 (70.6)
Nighttime (between 7p – 7a)			387 (27.5)
Not indicated			26 (1.9)
Highest nursing degree			
Diploma			132 ( 9.4)
Associate degree			511 (36.4)
Baccalaureate degree			633 (45.1)
Master's degree or higher			116 ( 8.3)
Not indicated			13 ( 0.9)
Primary Unit			
Administration / Management			69 ( 4.9)
Clinical inpatient unit			827 (58.9)
Data collection or Research			30 ( 2.1)
Education			60 ( 4.3)
Outpatient or Clinic			140 (10.0)
Procedural or Surgery			232 (16.5)
Other			40 ( 2.8)
Not indicated			7 ( 0.5)
Nursing Role			
Administrative or Management			151 (10.7)
Data Collector or Researcher			32 ( 2.3)
Educator			73 ( 5.2)
Staff nurse			1093 (77.8)
Other			51 ( 3.6)
Not indicated			5 ( 0.4)

Table 2

*Demographic Characteristics of Magnet and non-Magnet Nurses*

<b>Variable</b> <b>N (%) or Mean ± SD (Min, Max)</b>	<b>Magnet</b> <b>(n = 1,003)</b>	<b>Non-Magnet</b> <b>(n = 402)</b>
Gender		
Female	908 (91)	363 (90)
Male	64 (6)	20 (5)
Not indicated	31 (3)	19 (5)
Age	43.7 ± 11.8 (21,70)	43.8 ± 11.6 (23,70)
Years in Profession	17.2 ± 12.3 (0,46)	16.8 ± 1.9 (0,44)
Years in Current Role	8.0 ± 8.7 (0,40)	8.5 ± 9.1 (0,44)
Years on Current Unit	6.7 ± 7.5 (0,37)	6.3 ± 6.9 (0,38)
Hours worked in a week*	36.8 ± 8.1	37.4 ± 8.1
Work Status		
Full time	834 (83)	338 (84)
Part time	94 (9)	33 (8)
PRN	57 (6)	19 (5)
Not indicated	18 (2)	12 (3)
Shift worked		
Daytime (between 7a – 7p)	704 (70)	288 (72)
Nighttime (between 7p – 7a)	278 (28)	109 (27)
Not indicated	21 (2)	5 (1)
Highest nursing degree		
Diploma	96 (10)	36 (9)
Associate	337 (34)	174 (43)
Baccalaureate	476 (48)	157 (39)
Master's or higher degree	86 (9)	30 (8)
Not indicated	8 (<1)	5 (1)
Primary unit		
Administration / Management	45 (5)	24 (6)
Clinical inpatient	578 (58)	249 (62)
Data collection or research	25 (3)	5 (1)
Education	47 (5)	13 (3)
Outpatient or clinic	112 (11)	28 (7)
Procedural or surgery	163 (16)	69 (17)
Other	29 (3)	11 (3)
Not indicated	4 (<1)	3 (<1)
Nursing Role		
Administrative or management	112 (11)	39 (10)
Data collector or researcher	26 (3)	6 (2)
Educator	58 (6)	15 (4)
Staff nurse	769 (77)	324 (81)
Other	36 (4)	15 (4)
Not indicated	2 (<1)	3 (<1)

\*Note. Denotes hours worked in a workweek which varied from 0 to 80 hours/week.

Nurses perceived their work environment to be moderately empowering in both Magnet organizations and non-Magnet organizations. Perceptions of total empowerment were moderate in both Magnet (M = 20.7; SD = 3.81) and non-Magnet (M = 20.9; SD = 3.82) organizations. Magnet nurses reported that they had the greatest access to opportunity (M = 3.9; SD = 0.79) and the least access to resources (M = 3.2; SD = 0.82). Non-Magnet nurses reported that they had the greatest access to opportunity (M = 4.0; SD = 0.75) and the least access to resources (M = 3.1; SD = 0.86). Formal power in Magnet organizations (M = 3.1; SD = 0.86) was also rated lower than informal power (M = 3.5; SD = 0.80). Formal power in non-Magnet organizations (M = 3.2; SD = 0.90) was also rated lower than informal power (M = 3.6; SD = 0.79). Table 3 provides specific information regarding the structural empowerment in both types of organizations in this study.

*Table 3*

*Conditions of Work Effectiveness Questionnaire Scores\**

<b>Measure</b>	<b>Magnet (n = 1003)</b>	<b>Non-Magnet (n = 402)</b>	<b>p-value</b>
Total Empowerment ( $\alpha = .92$ )	20.7 ± 3.81	20.9 ± 3.86	0.492
Access to Information ( $\alpha = .92$ )	3.5 ± 0.90	3.5 ± 0.95	0.110
Access to Opportunity ( $\alpha = .82$ )	3.9 ± 0.79	4.0 ± 0.75	0.395
Access to Resources ( $\alpha = .84$ )	3.2 ± 0.82	3.1 ± 0.86	0.979
Access to Support ( $\alpha = .90$ )	3.4 ± 0.97	3.4 ± 0.97	0.103
Formal Power (JAS) ( $\alpha = .80$ )	3.1 ± 0.86	3.2 ± 0.90	0.680
Informal Power (ORS) ( $\alpha = .77$ )	3.5 ± 0.80	3.6 ± 0.79	0.002

\**Note.* All numbers reported are Mean ± SD except for p-value. Sample size for each comparison varied from 1213 to 1306 due to missing data.

The average PES score for Magnet nurses was 2.88 (SD = 0.60) and for non-Magnet nurses was 2.91 (SD = 0.53). In Magnet organizations, nurses were most satisfied in the practice environment with collegial nurse-physician relations (M = 3.08; SD = 0.60) and the least satisfied with nurse participation in hospital affairs in the practice environment (M = 2.77; SD = 0.59). In non-Magnet organizations, nurses were most satisfied in the practice environment with collegial nurse-physician relations (M = 3.08; SD = 0.60) and the least satisfied with staffing and resource adequacy (M = 2.58; SD = 0.71) in the practice environment. Table 4 provides specific information regarding the practice environment in Magnet and non-Magnet organizations.

Table 4

*Practice Environment Scale\**

<b>Measure</b>	<b>Magnet (n = 1003)</b>	<b>Non-Magnet (n = 402)</b>	<b>p-value</b>
Total Score ( $\alpha = .87$ )	2.88 $\pm$ 0.60	2.91 $\pm$ 0.53	0.419
Nurse Participation in Hospital Affairs ( $\alpha = .89$ )	2.77 $\pm$ 0.59	2.88 $\pm$ 0.62	0.030
Nursing Foundations for Quality of Care ( $\alpha = .86$ )	3.03 $\pm$ 0.48	3.03 $\pm$ 0.52	0.800
Nurse Manager Ability, Leadership, and Support of Nurses ( $\alpha = .88$ )	2.90 $\pm$ 0.70	2.95 $\pm$ 0.68	0.292
Staffing and Resource Adequacy ( $\alpha = .86$ )	2.58 $\pm$ 0.71	2.53 $\pm$ 0.76	0.371
Collegial Nurse-Physician Relations ( $\alpha = .87$ )	3.08 $\pm$ 0.60	3.13 $\pm$ 0.66	0.204

\**Note.* All numbers reported are Mean  $\pm$  SD except for p-value. Sample size for each comparison varied from 931 to 1056 due to missing data.

## Discussion

### Structural Empowerment

Results of the CWEQ – II questionnaire provided information concerning the state of the work environment and empowerment as described by Kanter (1977).

Empowerment scores, total and subscales, were good and advocate that nurses had varying access to Kanter’s empowerment structures within the organization. In a previous study, Laschinger (2008) found that nurses were moderately empowered (M = 19.14; SD = 3.3) and nurses believes that access to opportunity was the highest component (M = 4.05; SD = 0.75) in the Kanter’s theory. When comparing Magnet and

non-Magnet organizations in this study, nurses did rate empowerment as being moderate ( $M = 20.7$ ;  $SD = 3.86$ ) in Magnet and moderate ( $M = 20.9$ ;  $SD = 3.86$ ) in non-Magnet. Both types of organizations did show that access to opportunity as being the highest subscale which means that nurses have the opportunity to professionally grow and advance within the organization. This indicates that nurses have opportunities for gaining new knowledge and skills and for serving the organizations through meetings and councils. With the two organizations reporting access to resources as the least favorable category, organizations will need to provide the necessary equipment and supplies so that nurses can complete their job responsibilities more efficiently. Findings from other studies were similar to the results of empowerment scores in this study (Faulkner & Laschinger, 2008; Laschinger, 2008; Laschinger, Leiter, Day, Gilin-Oore, & Mackinnon, 2012; McDonald et al., 2010).

Even though their study did not specifically compare Magnet and non-Magnet organizations, Faulkner and Laschinger (2008) reported that empowered nurses who feel more respected in the work environment will be satisfied and committed. In this current study, the results were very similar with non-Magnet organizations having a slightly higher mean. The components of the Structural Empowerment Theory mirrored one another in both types of organizations. There was no statistical significance ( $p = 0.492$ ) between structural empowerment scores between the two types of organizations.

Other measures were also analyzed with empowerment scores to see if a relationship existed. Magnet organizations stress the importance of opportunities such as education (Kramer & Schmalenberg, 2004a). Nurses working in Magnet organizations

did overall have more baccalaureate or higher degrees (57%) in comparison to non-Magnet nurses. When interpreting education levels between both organizations, nurses with baccalaureate or higher degrees were more prevalent in Magnet organizations; however, the means were not significantly different by types of organizations ( $p = 0.395$ ). Nurses working in Magnet organizations average age ( $M = 43.7$ ;  $SD = 11.8$ ) was similar to the average age of non-Magnet nurses ( $M = 43.8$ ;  $SD = 11.6$ ). When reviewing the relationship between age with higher empowerment scores in both types of organizations, the scores mirrored one another with no statistical significance ( $p = 0.231$ ). Nurses work status of full time in Magnet organizations (83%) was similar to the full time work status of non-Magnet nurses (84%). When interpreting work status between both organizations, the means were very similar in both types of organizations with no statistical significance ( $p = 0.693$ ). In essence, the overall results indicate that structural empowerment's relationship with work status, education status, and age was comparable in both types of facilities.

### **Practice Environment**

When comparing Magnet and non-Magnet organizations in this study, nurses did perceive the practice environment similarly. The overall nurse practice environment mean score appears to be favorable. Magnet nurses had a mean score of 2.88 ( $SD = 0.60$ ) and non-Magnet nurses had an average score of 2.91 ( $SD = 0.53$ ). There was no statistical significance when comparing both types of organizations ( $p = 0.419$ ) on average total scores. Results from this study contradicted findings from Choi and Boyle

(2014) as their findings indicated that the practice environment was more favorable in Magnet organizations.

In terms of the presence of Magnet hospital traits, it was promising to have nurse-physician collegial relationships as the top scoring item. Nurses rated collegial nurse-physician relations as the highest subscale in both types of organizations with Magnet nurses having a mean score of 3.08 (SD = 0.60) and non-Magnet nurses having a mean score of 3.13 (SD = 0.66). The ranking of highest to lowest subscales mirrored one another in both types of organizations. Nursing foundation for quality of care was the next highest with mean scores of 3.03 (SD = 0.48) for Magnet nurses and 3.03 (SD = 0.52) for non-Magnet nurses. Nurse manager's ability, leadership, and support for nurses had mean scores of 2.90 (SD = 0.70) for Magnet nurses and 2.95 (SD = 0.68) for non-Magnet nurses. Nurse participation in hospital affairs had mean scores of 2.77 (SD = 0.59) for Magnet nurses and 2.88 (SD = 0.62) for non-Magnet nurses. Finally, staffing and resource adequacy had mean scores of 2.58 (SD = 0.71) for Magnet nurses and 2.53 (SD = 0.76) for non-Magnet nurses. This subscale of staffing and resource adequacy could be concerning as staffing and resources are vital to providing excellent patient care and providing satisfaction within the work place. It is evident that nurses feel that staffing is a concern, and this could be an area for improvement for the future with hospital administrators. Each subscale mean score was similar between both types of organizations resulting in no statistical significance between the two types of organizations.

### **Implications**

The results of this study provide a valuable description about whether or not a difference exists between Magnet and non-Magnet organizations with structural empowerment and the practice environment. Outcomes assessed included structural empowerment and the practice environment. These measurements compared the two different types of organizations to see whether or not a difference truly existed and where opportunities for improvement are needed. This information may assist other healthcare organizations in deciding about whether or not Magnet designation needs to be achieved or not. This research does provide guidance as to how nurses feel about their work environment. More research is needed to compare Magnet and non-Magnet organizations where similar institutions can be compared

### **Study Limitations**

The limitations associated with this research study must be considered. This study involved 21 healthcare organizations. Two corporate hospital organizations comprised 20 of the 21 hospitals participating with both corporations having both types of organizations, Magnet and non-Magnet facilities. Some non-Magnet hospitals were on the pathway of excellence for Magnet designation. Another limitation is that the environment from the healthcare organization may be different. Magnet organizations tended to reside in urban environments whereas non-Magnet organizations tended to reside in rural environments. The population served, as well as the size of the facility, by these different facilities varied which could certainly influence the perceptions of nurses regarding work environment and quality of care. Another limitation involved the length

of the survey and completion rates. Questions at the end of the survey tended to be left blank as the survey was comprised of four instruments and a demographic section. Finally, an electronic survey was used for this survey and a malfunction was detected in the first few days of survey distribution which may have prevented some nurses from completing the survey.

### **Conclusion**

This study provides comprehensive, descriptive and comparable information on nursing environments within 21 Magnet or non-Magnet healthcare organizations. The purpose of this study was to examine the practice environment and structural empowerment in both types of organizations. This study explored structural empowerment's influence on the practice environment. This research compared these outcome measures in Magnet and non-Magnet facilities. This research used Kanter's Structural Empowerment Theory as the framework to understand the impact of structural empowerment in the workplace in this sample (n = 1405). This framework was simple, but well designed in the inclusion of all the variables being examined. The model was also used to guide the discussion section, especially the interpretation of the findings.

The results of this study indicate that there are no statistical significances existing between Magnet and non-Magnet organizations when looking at structural empowerment and the practice environment in both types of organizations. Findings provide empirical evidence that both types of organizations are similar when assessing empowerment's influence of the work environment. The results provide insight as to how nurses view empowerment in their organization and as well as how they perceive the practice

environment within their respective institution. There are areas that need to be further addressed if healthcare administrators desire to retain the best staff and provide satisfaction within the work environment. Improving on aspects of the work environment could assist in promoting retention of employees while also improving job satisfaction. Structural empowerment is important in the workplace as nurses desired to be empowered in decision-making. Moreover, further exploration needs to be conducted to see what Magnet facilities can continue to make their claim as being superior in future outcomes.

CHAPTER V  
STRUCTURAL EMPOWERMENT'S INFLUENCE ON NURSING OUTCOMES  
IN MAGNET AND NON-MAGNET ORGANIZATIONS

**Introduction**

The American Nurses Credentialing Center's (ANCC) Magnet™ recognition program is the marker of distinction for hospitals when discussing excellence in care. Accompanying this designation is the feeling of an entitlement of superiority in hospital patient care outcomes and measurements as this designation is considered the pinnacle of all designations in healthcare throughout the United States (Kooker & Kamikawa, 2009). Since Magnet's inception in the 1980's, ANCC has promoted and encouraged this designation to be achieved by hospitals. Initially, Magnet was linked to recruiting and retaining nurses in order to provide superb care (Aiken, Buchan, Ball, & Rafferty, 2008; Flynn & McCarthy, 2008; Joyce & Crooks, 2007). In the early 1990's, ANCC identified Magnet hospitals as those organizations that promoted nursing excellence through work environments which promoted improved outcomes, increased job satisfaction, and reduced turnover (Caldwell, Roby-Williams, Rush, & Ricke-Kiely, 2009; Kramer, Maguire, & Brewer, 2011; McHugh & Stimpfel, 2012; Rodwell & Demir, 2013; Tuazon, 2007). Being designated as a Magnet organization provides hospitals with a robust nursing culture as hospitals strive to be the best. In 2010, approximately 7% of hospitals

had Magnet status (Lake, Shang, Klaus, & Dunton, 2010). Finally, Bennett et al. (2012) reported that a substantial variation in perceptions about professional nursing governance as Magnet hospitals scored higher than non-Magnet facilities when researched. Currently, ANCC claims that the benefits of Magnet designation include attracting and retaining top talent, improving patient care, safety, and satisfaction, and fostering a collaborative culture (retrieved on 9/14/4 from <http://www.nursecredentialing.org/Magnet/ProgramOverview>). However, do Magnet hospitals have more outstanding outcomes and superior staff compared to non-Magnet organizations as the ANCC claims?

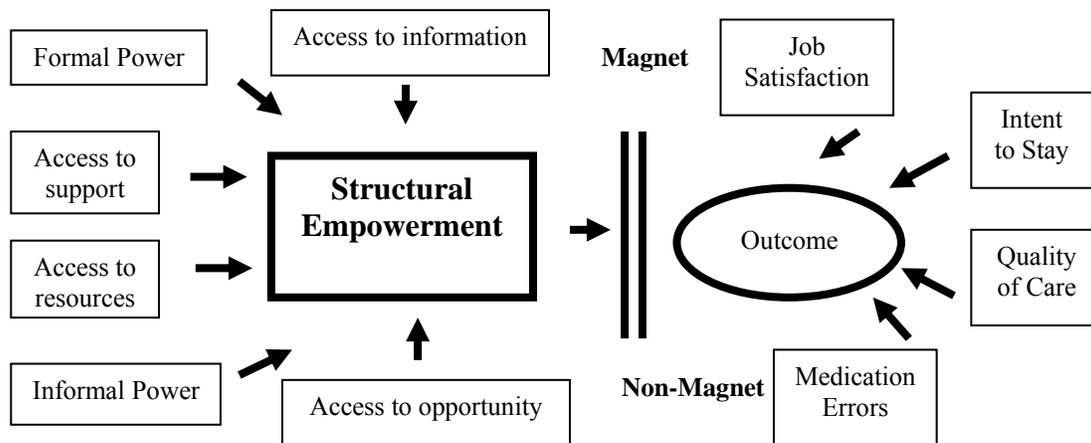
### **Purpose**

The purpose of this study was to examine structural empowerment's impact on nursing outcomes. This study explored structural empowerment's influence on two quality sensitive indicators which were job satisfaction and intent to stay. Additionally, the study examined structural empowerment's impact on two quality outcomes which were perceptions about medication errors and quality of care. This research compared these outcome measures in Magnet and non-Magnet facilities.

### **Conceptual Model**

As empowerment's definition is identified, Kanter's structural empowerment becomes the primary empowerment theory within the workplace. Kanter, renowned for her theory within the business sector, provides insight about empowerment and organizational commitment (Kanter, 1977). Kanter's structural empowerment theory provides the foundational work for many nurse scientists as her theory involves managers

taking specific actions to create high quality work environments that foster trust and enhance work effectiveness (Kanter, 1977; Laschinger, Leiter, Day, & Gilin, 2009; Stein & Kanter, 1980). Kanter's theory imparts a foundational premise in which motivated employees seek a committed work relationship (Laschinger, Wong, & Greco, 2006). The four components contributing to this healthy work relationship include access to support, resources, information, and opportunity with formal and informal power being essential to this phenomenon (Cowden & Cummings, 2012; Laschinger et al., 2012; Laschinger, Wilk, Cho, & Greco, 2009; McDonald, Tullai-McGuinness, Madigan, & Shively, 2010; Stein & Kanter, 1980). Kanter hypothesizes that access to these factors contribute to professional growth and organizational goal achievement (Kanter, 1977; Laschinger & Havens, 1996; Stein & Kanter, 1980). Also, formal and informal powers are imperative to this theory and assist with accomplishing goals for the organization (Chambers & Thompson, 2008). Formal power is defined by how nurses perceive their job role in terms of flexibility, visibility, and importance of the job in terms of creativity and innovation whereas informal power provides the nurse with the opportunity to establish networks with peers, sponsors, and subordinates (Davies, Laschinger, & Andrusyszyn, 2006; McDonald et al., 2010). By having the four structural components along with both types of power, the nurse can become empowered within the work setting which allows organizational goals to be accomplished (see Figure 3).



*Figure 3. Conceptual Framework Based on Kanter's Structural Empowerment.*

### **Review of Literature**

Understanding how important structural empowerment is and the outcomes that healthcare leaders desire in the workplace, a comprehensive literature review was conducted. The review of literature extends over the last two decades as this concept has been studied and measured with a variety of outcomes. The electronic databases Cumulative Index to Nursing and Allied Health (CINAHL), Journal Storage (JSTOR), Psychological Information (Psycinfo), Medlars On-line System (Medline), and Public Medline (PUBMED) were searched. Searches were limited to researches that were available in the English language and peer-reviewed journals. Search terms used included “burnout”, “burnout and nursing”, “empowerment”, “empowerment and nursing”, “empowerment and outcomes”, “engagement”, “engagement and empowerment”, “engagement and nursing”, “hospital reimbursement and quality”, “intent to stay”, “intent to stay and nursing”, “job satisfaction”, “job satisfaction and

empowerment”, “job satisfaction and engagement”, “job satisfaction and nursing”, “Magnet”, “Magnet and non-Magnet hospitals”, “Magnet hospitals”, “Magnet outcomes”, “nurse, empower, and employment”, “satisfaction, reimbursement, and hospital”, and “work engagement”. Additional articles were located on EBSCO data base or Google Scholar that examined the terms “empowerment and nursing”, “job satisfaction and nursing”, and “intent to stay and nursing”. More than 175 articles were reviewed. This review of literature about the state of science related to empowerment included articles from other professions and disciplines that could be influential to the outcomes related to this concept. The review of literature also included articles that looked at healthcare workers and the outcomes desired for this research.

### **Empowerment According to Other Disciplines**

Empowerment has been widely discussed throughout the literature. Page and Czuba (1999) identified empowerment in terms of a social process in which individuals gain control over their personal lives by challenging assumptions that involve power, assistance, achievement, and success. These authors believed that the concept is not formulaic but that the concept takes on many meanings in its definition as individuals attempt to gain control over their lives and situations (Page & Czuba, 1999). Ellefsen and Hamilton (2000) assent with empowerment being correlated with decision-making and delegation whereas Finegan and Laschinger (2001) believe that empowerment provides an excellent way of enhancing organizational attitudes of both genders.

Several disciplines have also defined empowerment. Oxford law defines this concept as permitting autonomous, equal, and non-discriminatory individuals to fully

participate in society regardless of religious, legal, or political perspectives (“Empowerment”, 2008). Other Oxford disciplines emphasize important linkages to this concept which incorporate accountability, decision-making, job fulfillment, health promotion, motivation, productivity, responsibility, and training (“Empowerment”, 2007; “Empowerment” edited by Heery & Noon, 2009; “Empowerment” edited by Law, 2009; “Empowerment”, 2010).

### **Professions Outside of Nursing**

When looking at the prison system, Farmer (2011) indicated that the work environment could be affected if employees were not empowered in decision-making. The organizational theory was the theoretical framework for this research. This framework supported three assumptions which include that decisions should not always be top down, delegation is needed in order for duties to be accomplished, and decision-making should be a shared process with employees. This research looked at relationships with supervisors, the prison system, job satisfaction, and burnout. Statistical analysis of this research included a bivariate analysis in which staff reported more positive relations in an empowered environment. However, staff burnout and staff satisfaction were not shown to have statistical significance. This research looked at a prison system in the East and the West (Farmer, 2011).

In the education system, Hermsen and Rosser (2008) found that career support and recognition for competence were found to be significant and positive indicators of job satisfaction. This researched was founded on two theoretical frameworks that included work engagement which identified with one’s role and job satisfaction within

the work environment. A survey was distributed to staff members in higher education in two different organizations. A total of 170 surveys, response rate of 58%, were collected for this research. Multiple linear regression analysis was performed to examine job satisfaction and engagement with work life. Career support and recognition for competence ( $p < 0.001$ ) were found to be statistically significant with job satisfaction. Also, working conditions ( $p < 0.001$ ) and external relations ( $p < 0.05$ ) were found to be significant and positively related to job satisfaction (Hermsen & Rosser, 2008).

Hashemi, Nadi, Hosseini, and Rezvanfar (2012) examined perceived organizational support, psychological empowerment, job satisfaction, organizational commitment, and entrepreneurial behavior in the agriculture industry. Through descriptive statistics, confirmatory analysis, and structural equation modeling, the authors found that employers must provide working conditions, in which the employees feel free, admired, motivated, and empowered. The authors found that perceived organizational support was correlated positively and significantly with psychological empowerment, job satisfaction, organizational commitment, and intrapreneurial behavior ( $p < 0.01$ ). Personnel perceptions of their organizational support were correlated significantly more with perceptions of their organizational commitment ( $p < 0.01$ ). Job satisfaction was correlated significantly with organizational commitment ( $p < 0.01$ ). Overall, intrapreneurial behavior was correlated significantly more with organizational commitment ( $p < 0.01$ ), job satisfaction ( $p < 0.01$ ), perceived organizational support ( $p < 0.01$ ) and psychological empowerment ( $p < 0.01$ ). Perceived organizational support and job satisfaction were strong antecedents of organizational commitment than that of

psychological empowerment as this has been strongly shown to improve performance and increase job satisfaction (Hashemi, Nadi, Hosseini, & Rezvanfar, 2012).

In the restaurant industry, Gill, Mathur, and Bhutani (2012) examined job satisfaction and work experience as employees covet for empowerment internationally. Confirmatory factor analysis was the statistical analysis performed for this research. Positive relationships between job satisfaction and the employee desire for empowerment as well as work experience and employee desire to empowerment were determined. Satisfied employees are more likely to desire this concept of empowerment as decision-making is crucial in the delivery of service to patrons (Gill, Mathur, & Bhutani, 2012).

### **Empowerment and Nursing Outcomes**

Laschinger, Leiter, Day, and Gilin (2009) examined the influence of an empowering work conditions and workplace incivility on nurses' experiences of burnout and retention. Three retention outcomes were measured in 612 Canadian nurses. These included job satisfaction, organizational commitment, and turnover intentions. Results from hierarchical multiple regression analyses showed that empowerment, workplace incivility, and burnout explained statistical significance in the three retention factors of job satisfaction ( $R^2 = 0.46$ ), organizational commitment ( $R^2 = 0.29$ ), and turnover intentions ( $R^2 = 0.28$ ). Empowerment, supervisor incivility, and cynicism most strongly predicted job satisfaction whereas emotional exhaustion, cynicism, and supervisor incivility most strongly predicted turnover intentions (Laschinger et al., 2009).

Faulkner and Laschinger (2008) showed that empowered nurses who feel more respected in the work environment will be satisfied and committed especially if the traits

of autonomy, confidence, meaningfulness and a feeling of being able to have an impact in the organization are promoted. These authors examined the relationship between structural and psychological empowerment and their effects on hospital nurses' perceptions and respect from a Canadian province. The sample included 282 nurses. Findings supported Kanter's theory which emphasized that nurses perceive themselves to be empowered and are more likely to feel respected in the work environment. Nurses reported being moderately empowered ( $M = 17.8$ ,  $SD = 3.3$ ). Nurses did report opportunity as the greatest empowering structure ( $M = 4.0$ ,  $SD = 0.79$ ). Other results included nurses reporting a sense of meaning at work ( $M = 4.2$ ,  $SD = 0.76$ ) but feeling that they made no significant impact in the organization ( $M = 2.5$ ,  $SD = 0.97$ ). Structural empowerment was significantly and positively related to perceived respect ( $r = 0.47$ ,  $p < 0.001$ ) as well as each of the structural empowerment factors (Faulkner & Laschinger, 2008).

When comparing different organizations, Laschinger, Almost, and Tuer-Hodes (2003) did a secondary analysis of three previous research studies conducted. Two studies involved staff nurses and one study involved nurse practitioners. The setting was in Canada. These authors reported about nurses' perceptions of workplace empowerment, Magnet characteristic, and job satisfaction in different work settings and showed how relationships between structural empowerment and Magnet organization characteristics were significant. Autonomy, control over practice, and positive nurse-physician relationships were shown to be significant with structural empowerment. Results were very similar to previous work conducted by Aiken in 2000. However,

access to information ranked high to the overall work environment indexes ( $r = 0.52$ ). Empowerment and Magnet hospital characteristics were significant predictors of job satisfaction ( $R^2 = 0.502$ ,  $F = 26.25$ ,  $df = 2.52$ ,  $p < 0.001$ ). Their results indicated that empowered work environments support professional practice as nurses in Magnet facilities reported lower levels of burnout and higher levels of job satisfaction (Laschinger, Almost, & Tuer-Hodes, 2003).

Tuazon (2007) discussed where evidence demonstrates positive outcomes related to Magnet affiliated facilities that allow nurses to be more autonomous and promote decision-making in practice as results showed improved patient satisfaction, enhanced physician satisfaction, and an increase in operating margin from 4% to 16% as Magnet hospitals outperformed non- Magnet hospitals. In a systematic review, Wagner et al. (2010) reported that structural empowerment, which is a component emphasized in Magnet recognition, demonstrated in health care settings supports healthier employees, reduces stress, and increases employee commitment to organizational goals, which overall culminates in improved organizational outcomes including improved patient outcomes. Ten articles were examined that represented six studies. These studies revealed associations between structural empowerment and psychological empowerment in registered nurses. This review concluded that having structural empowerment components contributed to a strong workforce and led to higher satisfaction scores and higher retention of nurses.

Lake, Shang, Klaus, and Dunton (2010) examined the relationship between Magnet hospitals, nursing staff, and patient falls. These authors reviewed data in a cross-

sectional study using 2004 National Database of Quality Indicators from over 5000 units in 108 Magnet and 528 non-Magnet hospitals. Multivariate models revealed that fall rates were 5% lower in Magnet facilities. Nursing working hours and Magnet status were significantly associated with fall rate. Productivity was negatively associated with fall rate. However, elements for nursing staff composition such as degrees, specialty certifications, and agency hours were not significantly associated with fall rates (Lake et al., 2010).

Feltner, Mitchell, Norris, and Wolfle (2008) interviewed 40 nurses in order to evaluate effective leadership characteristics at an acute care hospital. After characteristics were determined in the interview process, a survey was distributed to 70 nurses in order to rank order each characteristic. The order of rank for the characteristics were as follows: communication skills, fairness, job knowledge role model, dependable, participative partnership, confident, positive attitude, motivation, delegation, flexibility, compassionate, employee loyal, sets objective, and negotiation. These authors revealed that effective leaders need to create a work environment where staff becomes satisfied and productive so that the organization can be successful. The characteristics determined in this study would benefit in creating a satisfying environment (Feltner, Mitchell, Norris, & Wolfle, 2008).

Hader, Saver, and Steltzer (2006) showed data where Magnet facilities provide more services and benefits when compared to other facilities. In a sample of 978 participants, surveys were distributed to collect data about the workforce. Data revealed

that with each year, more nurses plan to retire and more plan to be leaving the profession on an annual basis.

Caldwell, Roby-Williams, Rush, and Ricke-Kiely (2009) tested hypothesis associated with readiness. These authors reported that Magnet organizations provide higher quality of care, but little research is known about nurses' attitudes and behaviors in Magnet organizations. In a sample of 306 registered nurses, these authors investigated factors that influenced the willingness to embrace change needed with a Magnet affiliated status. Hierarchical linear modeling was used for statistical analysis. Results revealed that nurses are more attracted to Magnet hospitals as these facilities allow nurses to learn and excel in their skills (Caldwell et al., 2009).

Manojlovich and Laschinger (2007) examined structural empowerment on professional factors contributing to nursing job satisfaction. Using a non-experiment design, 500 nurses were selected to be surveyed. A response rate of 66% was obtained (n = 332). Results showed that the Nursing Worklife Model explains nursing job satisfaction and adding structural empowerment to the Nursing Worklife Model will provide additional variance to job satisfaction. Strong associations were correlated between the subscales of empowerment and the practice environment that looked specifically at the nursing worklife. This research showed that empowerment was predictive of nurses' views of 'Magnet-like' nature of the work environment which positively impacted job satisfaction (Manojlovich & Laschinger, 2007).

## **Job Satisfaction**

Job Satisfaction has been defined as an individual enjoying their work while also having adequate resources and support (Davies et al., 2006). Nurses that report a higher level of job satisfaction have a greater likelihood to remain in their current organization (Ingersoll, Olsan, Drew-Cates, DeVinney, & Davies, 2002).

Multiple research studies have identified correlations between job satisfaction and structural empowerment. Davies, Laschinger, and Andrusyszyn (2006) conducted a non-experimental with clinical educators in a hospital setting in Ontario. These authors examined the relationships between clinical educators' perceptions between empowerment, job tension, and job satisfaction. The sample size included 141 participants. Clinical nurse educators perceived themselves moderately empowered ( $M = 13.09$ ,  $SD = 2.28$ ). The most empowering structure was opportunity ( $M = 3.67$ ,  $SD = 0.59$ ) whereas the least empowerment factor was resources ( $M = 2.80$ ,  $SD = 0.66$ ). Clinical educators rated formal power ( $M = 3.25$ ,  $SD = 0.39$ ) and informal power ( $M = 3.38$ ,  $SD = 0.56$ ) as moderate. Job satisfaction was rated as being moderate ( $M = 3.54$ ) with greatest satisfaction being with scheduling ( $M = 4.18$ ) and least satisfaction with the balance of work and family ( $M = 3.19$ ) and control and responsibility aspects of the job ( $M = 3.20$ ). Results also revealed empowerment being a significant predictor ( $\beta = -0.598$ ,  $t = -5.689$ ,  $p < 0.001$ ). Hierarchical multiple regression indicated that there was a strong positive relationship between overall empowerment and overall satisfaction ( $r = 0.641$ ,  $p < 0.001$ ). Overall job satisfaction was most strongly related to access to support ( $r = 0.597$ ,  $p < 0.001$ ), followed by access to information ( $r = 0.550$ ,  $p < 0.001$ ), access to

opportunity ( $r = 0.510, p < 0.001$ ), and access to resources ( $r = 0.470, p < 0.001$ ) (Davies et al., 2006). Having specific organizational structures in the workplace are associated with higher employee job satisfaction.

Ning, Zhong, Libo, and Qiuji (2009) examined Kanter's structural empowerment specifying the relationship among demographics, structural empowerment, and job satisfaction. A correlational, cross-sectional design was used with a sample of 650 full time nurses in six Chinese hospitals. Results showed that a positive, statistical correlation existed between structural empowerment and job satisfaction ( $r = 0.547, p < 0.001$ ) as employees that are satisfied in the work environment are more likely to demonstrate higher levels of work performance (Ning, Zhong, Libo, & Qiuji, 2009).

Ingersoll, Olsan, Drew-Cates, DeVinney, and Davies (2002) defined the characteristics of the nursing work force in New York and determined the nurses' level of job satisfaction and commitment to work. Surveys were distributed randomly to nurses. Sample size was 1575 nurses. Items addressed on the survey included leaving or staying within the organization, job satisfaction, and organizational commitment. Moderate to strong positive correlations were revealed between organizational commitment and job satisfaction. This research showed that nurses with high levels of job satisfaction report a likelihood of remaining at their current organization and that higher degree nurses are more likely to be satisfied in comparison to those with lesser degrees. Overall job satisfaction was significantly higher for nurses who intended to remain at the same employer in the same job than for nurses who intended to stay at the same employer, but change jobs and nurses who intended to change employers ( $F = 16.4; df = 5; p < 0.001$ ).

Regression analysis identified organizational commitment ( $p < 0.001$ ), but not overall job satisfaction, as predictive of intent to stay or leave (Ingersoll et al., 2002).

Laschinger, Finegan, Shamian, and Wilk (2004) conducted a longitudinal predictive study looking at linking changes of structural and psychological empowerment with job satisfaction. Using structural equation modeling, a good fit was determined from 185 randomly assigned nurses ( $R^2 = 0.616$ ,  $X^2 = 667.455$ ,  $df = 342$ ,  $IFI = 0.979$ ,  $CFI = 0.979$ ,  $RMSEA = 0.072$ ). Results showed that structural empowerment produced statistical significant changes in job satisfaction ( $\beta = 0.70$ ). When changes occurred in structural empowerment components, changes also occurred in job how nurses viewed job satisfaction. Results also revealed that employees who are empowered are generally more satisfied in their work environments (Laschinger, Finegan, Shamian, & Wilk, 2004).

Laschinger, Finegan, Shamian, and Wilk (2001) tested an expanded model based upon Kanter's work which looked at structural empowerment, psychological empowerment, job strain, and work satisfaction. A predictive, non-experimental design was utilized. The authors collected data from 404 Canadian nurses. Structural equation modeling showed a good fit for the suggested expanded model ( $X^2 = 1140$ ,  $df = 545$ ,  $X^2/df$  ratio = 2.09,  $CFI = 0.986$ ,  $RMSEA = 0.050$ ). Nurses felt that structural empowerment in the work environment resulted in higher levels of psychological empowerment environments. Providing empowering structures at work allows for employees to be satisfied while also providing a sense that work is meaningful (Laschinger, Finegan et al., 2001).

## **Intent to Stay**

Intent to stay is defined as the likelihood of an individual continuing employment with their current organization (Cowden & Cummings, 2012). Intent to stay has been negatively associated with burnout as employees leave their current position to pursue other opportunities that they feel more welcoming. As nurses represent the largest percentage of healthcare workers at medical facilities, organizations desire employees to be engaged and remain in their current positions within the company so that turnover doesn't occur (Jenaro, Flores, Orgaz, & Cruz, 2010). Budin, Brewer, Chao, and Kovner (2013) emphasize that retaining nurses can contribute to patient safety as they surveyed nurses and established relationships between work behaviors and nursing outcomes.

Nemcek (2007) performed a descriptive, correlation study with a sample of 136 nurses that looked at the relationship of job satisfaction with life and self-nurturance. Self-nurturance, career satisfaction, and life satisfaction were positively correlated with one other. As self-nurturing behaviors and career satisfaction increased, life satisfaction increased. This research found that quality of care of care is directly associated with nurses remaining in their positions (Nemcek, 2007).

## **Perception about Quality of Care and Perception about Medication Errors**

The Institute of Medicine (IOM) report emphasizes that nurses work environments need to be improved while also improving safety and quality of care (IOM, 2010 October). Improving safety and quality care may include reviewing and examining the work environment and workforce staffing. As Magnet organizations are upheld to exemplify the best in healthcare, the expectation is that outcomes are superior in these

organizations. Outcomes measured and evaluated can include, but are not limited to, quality of care and medication errors as well as job satisfaction and intent to stay.

Aiken and Poghosyan (2008) performed a descriptive cross-sectional study in which an evaluation of an intervention for professional practice in Armenia and Russia. Interventions included changes in nurses' practice environments, nurse reported patient quality of care, and nurse burnout based upon initiatives from the ANCC Forces of Magnet. Nurses were asked to rate on a four point Likert scale about quality of care. Findings showed improvements in the nurse practice environment that were consistent with an evolving professional nurse practice model as emphasized by the ANCC and Magnet. Markers of patient-care quality also improved over the course of the study. The authors found that practice environment improvements occurred after the intervention (Aiken & Poghosyan, 2008).

Aiken, Buchan, Ball, and Rafferty (2008) tested the impact of Magnet principles of improving work environment of nurses. After a two year implementation period of Magnet principles based upon evidence-based standards and Magnet status awarded, quality of care improved and job satisfaction increased. Quality of care and job satisfaction advanced and was attributed to improving the work environment (Aiken et al., 2008).

Friese (2005) examined practice environments and outcomes of nurses working in oncology in Magnet affiliated organizations. In this secondary analysis study, there were 1956 nurses involved with 305 nurses working in oncology. Twenty-two hospitals were part of this study with only seven being Magnet. Results from this study showed that

oncology nurses benefited from working in Magnet organizations as outcomes tended to be superior. This research showed that adequate staffing and resources are necessary components that are needed to accomplish optimal outcomes (Friese, 2005).

Kendall-Gallagher and Blegen (2009) explored the association between certified nurses working in the hospital and risk of harm to the patients. This study involved a secondary analysis in which hierarchical linear modeling was used to determine relationships between certification rates, organization characteristics such as Magnet, staffing, and education, rates of medication errors, falls, skin breakdowns, and nosocomial infections. The setting involved critical care. Findings showed that total hours of care were positively associated to medication errors and specialty certification and competence of registered nurses are related to patient safety (Kendall-Gallagher & Blegen, 2009).

McHugh and Stimpfel (2012) examined the validity of nurses' responses about quality of care. These authors found a 10% increase in the proportion of nurses reporting excellent quality of care. This percentage increase was associated with lower odds of mortality, greater patient satisfaction, and higher composite scores of specific disease conditions. Nurses did relate quality of care with hospital performance (McHugh & Stimpfel, 2012).

## **Methodology**

### **Design**

This research utilized a correlational, cross-sectional design to assess the relationship between structural empowerment and job satisfaction, intent to stay in the

work setting, perceptions about quality of care, and perception about medication errors respectively in Magnet and non-Magnet affiliated hospitals. Also, the practice environment was evaluated to see if Magnet hospitals are superior in components that cater to this designation. Nursing quality data, quality of care and medication errors, were also collected. A cross-sectional design allowed data to be collected only once during a single period. An online survey was distributed to eligible nurse participants that work in both types of hospitals, Magnet and non-Magnet over a period of one month. An electronic survey ensured nurses' anonymity while providing convenience as nurses could complete the survey at any computer with internet access.

### **Sample**

The target population was nurses working at organizations that were either Magnet affiliated or non-Magnet affiliated. One organization was comprised of 14 hospitals that were located throughout North Carolina and Virginia. Another organization had six hospitals located in the central part of the state of North Carolina. One other non-Magnet rural and community based facility was included in this research. A total of 21 hospitals were used to recruit participants. All of these facilities were purposely selected as representative of Magnet and non-Magnet organizations. All of the healthcare organizations participating in this research were not for profit. The organizations invited to participate were chosen due to the proximity of the investigator's location and employment affecting approximately 6500 nurses. All nurses, including leaders as well as staff nurses, were eligible for this study.

## Methods

The researcher met with the nursing research councils of the two major organizations and corresponded via electronically and telephonic to the one smaller rural facility. The meetings were conducted to obtain permission to conduct the research at their respective institutions or organizations. Nurse participants were recruited through the healthcare system's electronic mail system. An email was sent to all nurses working for the specific market of the organizations chosen. The email contained an electronic letter explaining the purpose and importance of the study. A survey link was embedded within the email which directed them to an independent website for data collection. Access to the link was available through any computer that had internet access. The survey was available for approximately four weeks for data collection. To assure anonymity, no identification codes were linked to any completed electronic surveys.

After analyzing the research questions and study hypotheses, it was determined that five hypotheses required the largest sample size for adequate statistical power to detect an association between empowerment subscales and the measure being evaluated. A medium effect size of Cohen's  $f^2 = 0.25$  between structural empowerment level and the other measures was detected with a 2-way logistic regression with at least 80% power when the sample size was 209 nurses, assuming a two-tailed type I error = 0.00625 (i.e., 0.05/8 for the eight types of job satisfaction) and adjusting for gender, race/ethnicity, age, years in nursing, years in current nursing position, years in nursing, education level, length of shift, professional job role, typical shift worked, and average hours worked per week.

## **Human Subject Protection**

An Institutional Review Board (IRB) application was submitted for approval to the University of North Carolina at Greensboro (UNCG) IRB as well as each of the organization's IRB where the study occurred. If a facility did not have an IRB, a letter of permission was obtained by the nursing director at the facility and submitted to UNCG.

## **Instruments**

Five instruments were used for data collection: (a) a researcher designed demographic and information form, (b) Conditions of Work Effectiveness– II (CWEQ-II), (c) Job Satisfaction Scale (JSS), (d) Anticipated Turnover Scale (ATS), and (e) Practice Environment Scale (PES).

## **Demographic Information Form**

The demographic information form was developed for this study to obtain characteristics about the nurse participants. The individual information collected included the participant's place of employment, gender, race, age, number of years in nursing, number of years in current nursing role, number of years on the nursing unit, number of hours worked in a typical week, length of shift worked, shift of work, work status, primary unit of employment, job role, and education. Also, the individual was asked if their organization was on the pathway for excellence for Magnet. These measures were selected from a review of the literature on structural empowerment and Magnet organizations (Kramer et al., 2011; McDonald et al., 2010; Ning et al., 2009; Ridley, Wilson, Harwood, & Laschinger, 2009; Tigert & Laschinger, 2004).

## **Conditions of Work Effectiveness – II (CWEQ-II)**

Structural empowerment was measured by the CWEQ-II. The questionnaire consists of 19 items, composed of six subscales, and uses a 5-point Likert scale that ranges from none to a lot. The subscales include access to information, resource, opportunity, and support as well as formal and informal power. Scores are determined by summing items, with high scores representing high levels of the construct. Laschinger et al. (2001) validated the factor structure of CWEQ-II and recommended creating a total score by summing the six subscales with the scores ranging from 6 to 30. Various research studies have reported that the Cronbach alpha for reliability for the different components of structural empowerment ranged from 0.68 to 0.93 (Armstrong & Laschinger, 2006; Ellefsen & Hamilton, 2000; Faulkner & Laschinger, 2008; Hauck, Griffin, & Fitzpatrick, 2011; Krapohl, Manojlovich, Redman, & Zhang, 2010; Laschinger, 2008; Laschinger et al., 2003; Laschinger, Wong, Grau, Read, & Stam, 2011; Ning et al., 2009; Purdy, Laschinger, Finegan, Kerr, & Oliveria, 2010; Sabiston & Laschinger, 1995; Tigert & Laschinger, 2004). Manojlovich and Laschinger (2007) reported that content and construct validity have been established, and Tigert and Laschinger (2004) stated that validity had been substantiated by confirmatory factor analysis (Laschinger, 2008; Laschinger et al., 2011; Ridley et al., 2009). A 2-item global empowerment scale correlated positively with CWEQ-II ( $r = 0.56$ ) which supports the construct validity of the instrument (Hauck et al., 2011; Ning et al., 2009).

### **Job Satisfaction Scale (JSS)**

Job satisfaction was measured by the JSS. This questionnaire consists of 36 items designed to measure job satisfaction, and this tool uses a six point Likert scale to evaluate responses. This instrument measures several scales which include pay, promotion, supervision, fringe benefits, contingent rewards (performance based upon rewards), operating procedures (required rules and procedures), coworkers, nature of work, and communication. Cronbach alpha reliabilities are as follow: pay (0.75), promotion (0.73), supervision (0.82), fringe benefits (0.73), contingent rewards (0.76), operating procedures (0.62), coworkers (0.60), nature of work (0.78), and communication (0.71). Total Cronbach alpha reliability is 0.91 for all facets of this instrument (Spector, 1985). The JSS was examined from the 2004 National Database of Nursing Quality Indicators<sup>®</sup> which examined job satisfaction among direct care nurses (Klaus, Ekerdt, & Gajewski, 2012).

### **Anticipated Turnover Sale (ATS)**

Intent to stay was measured by using the ATS that looks at the individual's perception or opinion about voluntarily leaving the organization. The ATS contains 12 items that uses a seven point Likert scale. The Cronbach alpha for reliability has been estimated at 0.84 with one study reported a value of 0.88 (Hauck et al., 2011).

### **Practice Environment Scale (PES)**

The practice environment was measured using Lake's PES of the Nursing Work Index. This instrument consists of 31 items that measure the components of nursing participation, nursing foundation for care, management ability, adequate staff, and

collaborative relationships (Armstrong & Laschinger, 2006). Cronbach alpha reliabilities range from 0.71 to 0.80 with subscales ranging from 0.65 to 0.84.

### **Quality of Care**

Quality of care was measured by asking three questions. One item, which has been used to evaluate perceived quality of care, has been used repetitively in multiple studies (Aiken & Poghosyan, 2009; Laschinger, 2008; McHugh & Stimpfel, 2012). Two other questions will be asked in addition to evaluate quality of care (Aiken et al, 2008; Ridley et al., 2009). There have been no studies that report reliability or validity. Multiple studies have examined nursing and quality of care (Aiken & Poghosyan, 2009; Aiken et al., 2008; McHugh & Stimpfel, 2012; Nemcek, 2007; Laschinger, 2008; Ridley et al., 2009; Sochalski, 2004).

### **Medication Errors**

Medication errors were measured by asking one question. This one item, which has been used to evaluate perception about medication errors, has been asked in multiple studies (Purdy et al., 2010; Sochalski, 2004).

### **Data Analyses**

Data were analyzed using SPSS 19.0 software (SPSS Inc., Chicago, IL). Descriptive statistics were performed to assess for outliers. Assumptions of analyses were checked including normality, linearity, and homoscedasticity where appropriate. The data were examined to determine if they were theoretically out of range. A two-sided  $p$ -value  $< 0.05$  was considered statistically significant.

## Results

### Sample Demographics

The sample consisted of 1405 nurses from twenty-one hospitals located in North Carolina and Virginia. There were 1003 nurses from Magnet and 402 nurses from non-Magnet hospitals who participated in this survey. Nurse participant ages ranged from 21 to 70 with the average age for Magnet nurses being 43.69 (SD = 11.8) and the average age for non-Magnet nurses being 43.76 (SD = 11.6). The majority of the sample was women (90.5%) with 90.5% female nurses in Magnet hospitals and 90.3% female in non-Magnet hospitals. The majority of the sample worked day time hours (70.6%), Magnet hospitals having 70.2% and non-Magnet hospitals having 71.6%. The average number of hours working in a given week for Magnet nurses was 36.8 (SD = 8.1) compared to 37.4 (SD = 8.1) for non-Magnet nurses. The majority of the sample worked full time (83.4%) with Magnet hospitals being 83.2% and non-Magnet hospitals being 84.1%.

Years in the nursing profession for nurse participants ranged from less than one year to 46 years, with an average of 17.2 years (SD = 12.3) for Magnet nurses being relative to 16.8 years (SD = 11.9) for non-Magnet nurses. Years in the nurses' current role ranged from less than one year to 44 years with the average years in current role for Magnet nurses being 8 years (SD = 8.7) and the average years in current role for non-Magnet nurses being 8.5 years (SD = 9.1). The range of years working on the current unit varied from less than one year to 38 years with the average number of years working on the current unit in Magnet organizations being 6.7 years (SD = 7.4) and the average number of years working on the current unit in non-Magnet being 6.3 years (SD = 6.9).

A slight majority of nurse participants had baccalaureate or higher degrees (53.4%), with Magnet nurses having a baccalaureate or higher degree (56.5%) and non-Magnet nurses having a baccalaureate or higher degree (46.1%). The majority of the sample worked in clinical inpatient areas (58.9%) with Magnet nurses working in clinical inpatient areas (57.6%) and non-Magnet nurses working in clinical inpatient areas (61.9%). The majority of the sample was staff nurses (77.8%) with Magnet staff nurses (76.7%) and non-Magnet staff nurses (80.6%). Tables 5 and 6 provide specific information regarding the demographics of the sample.

Table 5

Overall Demographic Characteristics of the Study Sample (N = 1405)

Variable	Minimum	Maximum	N(%) or Mean ± SD
Gender			
Female			1271 (90.5)
Male			84 ( 6.2)
Not indicated			50 ( 3.6)
Age	21	70	43.71 ± 11.8
Years in Profession	0	46	17.1 ± 12.2
Years in Current Role	0	44	8.1 ± 8.9
Years on Current Unit	0	38	6.6 ± 7.3
Hours worked in a week*			37.0 ± 8.1
Work Status			
Full time			1172 (83.4)
Part time			127 ( 9.0)
PRN			76 ( 5.4)
Not indicated			30 ( 2.1)
Shift worked			
Daytime (between 7a – 7p)			992 (70.6)
Nighttime (between 7p – 7a)			387 (27.5)
Not indicated			26 (1.9)
Highest nursing degree			
Diploma			132 ( 9.4)
Associate degree			511 (36.4)
Baccalaureate degree			633 (45.1)
Master's degree or higher			116 ( 8.3)
Not indicated			13 ( 0.9)
Primary Unit			
Administration / Management			69 ( 4.9)
Clinical inpatient unit			827 (58.9)
Data collection or Research			30 ( 2.1)
Education			60 ( 4.3)
Outpatient or Clinic			140 (10.0)
Procedural or Surgery			232 (16.5)
Other			40 ( 2.8)
Not indicated			7 ( 0.5)
Nursing Role			
Administrative or Management			151 (10.7)
Data Collector or Researcher			32 ( 2.3)
Educator			73 ( 5.2)
Staff nurse			1093 (77.8)
Other			51 ( 3.6)
Not indicated			5 ( 0.4)

Table 6

*Demographic Characteristics of Magnet and non-Magnet Nurses*

<b>Variable</b> <b>N (%) or Mean ± SD (Min, Max)</b>	<b>Magnet</b> <b>(n = 1,003)</b>	<b>Non-Magnet</b> <b>(n = 402)</b>
Gender		
Female	908 (91)	363 (90)
Male	64 (6)	20 (5)
Not indicated	31 (3)	19 (5)
Age	43.7 ± 11.8 (21,70)	43.8 ± 11.6 (23,70)
Years in Profession	17.2 ± 12.3 (0,46)	16.8 ± 1.9 (0,44)
Years in Current Role	8.0 ± 8.7 (0,40)	8.5 ± 9.1 (0,44)
Years on Current Unit	6.7 ± 7.5 (0,37)	6.3 ± 6.9 (0,38)
Hours worked in a week*	36.8 ± 8.1	37.4 ± 8.1
Work Status		
Full time	834 (83)	338 (84)
Part time	94 (9)	33 (8)
PRN	57 (6)	19 (5)
Not indicated	18 (2)	12 (3)
Shift worked		
Daytime (between 7a – 7p)	704 (70)	288 (72)
Nighttime (between 7p – 7a)	278 (28)	109 (27)
Not indicated	21 (2)	5 (1)
Highest nursing degree		
Diploma	96 (10)	36 (9)
Associate	337 (34)	174 (43)
Baccalaureate	476 (48)	157 (39)
Master's or higher degree	86 (9)	30 (8)
Not indicated	8 (<1)	5 (1)
Primary unit		
Administration / Management	45 (5)	24 (6)
Clinical inpatient	578 (58)	249 (62)
Data collection or research	25 (3)	5 (1)
Education	47 (5)	13 (3)
Outpatient or clinic	112 (11)	28 (7)
Procedural or surgery	163 (16)	69 (17)
Other	29 (3)	11 (3)
Not indicated	4 (<1)	3 (<1)
Nursing Role		
Administrative or management	112 (11)	39 (10)
Data collector or researcher	26 (3)	6 (2)
Educator	58 (6)	15 (4)
Staff nurse	769 (77)	324 (81)
Other	36 (4)	15 (4)
Not indicated	2 (<1)	3 (<1)

\*Note. Denotes hours worked in a workweek which varied from 0 to 80 hours/week.

Four instruments (Conditions of Work Effectiveness – II, Job Satisfaction Scale, Anticipated Turnover Scale, and Practice Environment Scale) required scores to be calculated for this research. The instruments had Cronbach alpha coefficients for total scores ranging from 0.87 to 0.93. Tables 3 – 6 provide the specific estimates for Cronbach’s alphas for each of the instruments.

Nurses perceived their work environment to be moderately empowering in both Magnet organizations and non-Magnet organizations. Perceptions of total empowerment were moderate in both Magnet ( $M = 20.7$ ;  $SD = 3.81$ ) and non-Magnet ( $M = 20.9$ ;  $SD = 3.82$ ) organizations. Magnet nurses reported that they had the greatest access to opportunity ( $M = 3.9$ ;  $SD = 0.79$ ) and the least access to resources ( $M = 3.2$ ;  $SD = 0.82$ ). Non-Magnet nurses reported that they had the greatest access to opportunity ( $M = 4.0$ ;  $SD = 0.75$ ) and the least access to resources ( $M = 3.1$ ;  $SD = 0.86$ ). Formal power in Magnet organizations ( $M = 3.1$ ;  $SD = 0.86$ ) was also rated lower than informal power ( $M = 3.5$ ;  $SD = 0.80$ ). Formal power in non-Magnet organizations ( $M = 3.2$ ;  $SD = 0.90$ ) was also rated lower than informal power ( $M = 3.6$ ;  $SD = 0.79$ ). Table 7 provides specific information regarding the structural empowerment in both types of organizations in this study.

Table 7

Conditions of Work Effectiveness Questionnaire Scores (Mean ± SD)

Measure*	Magnet (n = 1003)	Non-Magnet (n = 402)	p-value
Total Empowerment ( $\alpha = .92$ )	20.7 ± 3.81	20.9 ± 3.86	0.492
Access to Information ( $\alpha = .92$ )	3.5 ± 0.90	3.5 ± 0.95	0.110
Access to Opportunity ( $\alpha = .82$ )	3.9 ± 0.79	4.0 ± 0.75	0.395
Access to Resources ( $\alpha = .84$ )	3.2 ± 0.82	3.1 ± 0.86	0.979
Access to Support ( $\alpha = .90$ )	3.4 ± 0.97	3.4 ± 0.97	0.103
Formal Power (JAS) ( $\alpha = .80$ )	3.1 ± 0.86	3.2 ± 0.90	0.680
Informal Power (ORS) ( $\alpha = .77$ )	3.5 ± 0.80	3.6 ± 0.79	0.002

\*Note. All numbers reported are Mean ± SD except for p-value. Sample size for each comparison varied from 1213 to 1306 due to missing data.

When examining job satisfaction, nurses perceived their work environment to be slightly satisfying (M = 146.01; SD = 27.18) with Magnet nurses having an average of 145.89 (SD = 26.98) and non-Magnet nurses having an average of 146.36 (SD = 27.79). In Magnet organizations, nurses were most satisfied with nature of the work (M = 19.83; SD = 3.53) and the least satisfied with pay at work (M = 13.29; SD = 4.75). In non-Magnet organizations, nurses were most satisfied with nature of the work (M = 20.49; SD = 3.68) and the least satisfied with promotions at work (M = 13.52; SD = 4.42). There was no statistical significance when looking at average total job satisfaction scores when comparing Magnet and non-Magnet organizations ( $p = 0.810$ ). Table 8 provides specific information regarding job satisfaction in Magnet and non-Magnet organizations.

Table 8

*Job Satisfaction Scale (Mean ± SD)*

<b>Measure*</b>	<b>Magnet (n = 1003)</b>	<b>Non-Magnet (n = 402)</b>	<b>p-value</b>
Total Job Satisfaction ( $\alpha = .93$ )	145.89 ± 26.98	146.36 ± 27.79	0.810
Pay ( $\alpha = .80$ )	13.29 ± 4.75	13.91 ± 4.72	0.055
Promotion ( $\alpha = .79$ )	13.35 ± 4.30	13.52 ± 4.42	0.567
Supervision ( $\alpha = .86$ )	19.38 ± 4.51	19.46 ± 4.64	0.618
Fringe Benefits ( $\alpha = .77$ )	15.00 ± 4.27	14.51 ± 4.39	0.089
Contingent Rewards ( $\alpha = .84$ )	15.05 ± 4.93	14.95 ± 4.98	0.779
Operating Procedures ( $\alpha = .57$ )	14.21 ± 3.85	13.69 ± 4.14	0.050
Coworkers ( $\alpha = .72$ )	18.75 ± 3.76	18.97 ± 3.68	0.517
Nature of Work ( $\alpha = .80$ )	19.83 ± 3.53	20.49 ± 3.30	0.006
Communication ( $\alpha = .73$ )	16.84 ± 4.10	16.57 ± 4.34	0.332

\**Note.* All numbers reported are Mean ± SD except for *p*-value. Sample size for each comparison varied from 999 to 1121 due to missing data.

When examining anticipated turnover, nurses perceived that they would, on average, slightly agree that they would not likely be terminating their employment in their present job role ( $N = 3.1$ ;  $SD = 1.20$ ). Magnet nurses had an average score of 3.2 ( $SD = 1.20$ ) whereas non-Magnet nurses had an average score of 3.0 ( $SD = 1.19$ ). Table 9 provides specific information regarding anticipated turnover in Magnet and non-Magnet organizations.

Table 9

*Anticipated Turnover Scale (Mean ± SD)*

<b>Measure*</b>	<b>Magnet (n = 1003)</b>	<b>Non-Magnet (n = 402)</b>	<b>p-value</b>
Anticipated Turnover Score ( $\alpha = .87$ )	3.12 ± 1.20	3.06 ± 1.19	0.096

\**Note.* All numbers reported are Mean ± SD except for *p*-value. Overall sample size for comparison was 1241 due to missing data.

When examining the practice environment, Magnet nurses having an average score of 2.88 (SD = 0.60) and non-Magnet nurses having an average score of 2.91 (SD = 0.53) when computing the average score of the Practice Environment Scale instrument. In Magnet organizations, nurses were most satisfied in the practice environment with collegial nurse-physician relations (M = 3.08; SD = 0.60) and the least satisfied with nurse participation in hospital affairs in the practice environment (M = 2.77; SD = 0.59). In non-Magnet organizations, nurses were most satisfied in the practice environment with collegial nurse-physician relations (M = 3.08; SD = 0.60) and the least satisfied with staffing and resource adequacy (M = 2.58; SD = 0.71) in the practice environment. Table 10 provides specific information regarding the practice environment in Magnet and non-Magnet organizations.

Table 10

*Practice Environment Scale (Mean ± SD)*

<b>Measure*</b>	<b>Magnet (n = 1003)</b>	<b>Non-Magnet (n = 402)</b>	<b>p-value</b>
Total Score ( $\alpha = .87$ )	2.88 ± 0.60	2.91 ± 0.53	0.419
Nurse Participation in Hospital Affairs ( $\alpha = .89$ )	2.77 ± 0.59	2.88 ± 0.62	0.030
Nursing Foundations for Quality of Care ( $\alpha = .86$ )	3.03 ± 0.48	3.03 ± 0.52	0.800
Nurse Manager Ability, Leadership, and Support of Nurses ( $\alpha = .88$ )	2.90 ± 0.70	2.95 ± 0.68	0.292
Staffing and Resource Adequacy ( $\alpha = .86$ )	2.58 ± 0.71	2.53 ± 0.76	0.371
Collegial Nurse-Physician Relations ( $\alpha = .87$ )	3.08 ± 0.60	3.13 ± 0.66	0.204

\*Note. All numbers reported are Mean ± SD except for p-value. Sample size for each comparison varied from 931 to 1056 due to missing data.

When examining the perceptions about medication errors and quality of care, nurses reported that they never to rarely have had a medication error within the past year (91.8%). In Magnet organizations, nurses perceived that they never to rarely have had a medication error within the past year (92.2%). In non-Magnet organizations, nurses perceived that they never to rarely have had a medication error within the past year (90.5%). As for quality of care, nurses perceived that the quality of care being delivered to patients on their last shift as excellent (59.4%). In Magnet organizations, nurses perceived that they provided excellent care (60.6%). In non-Magnet organizations, nurses perceived that they provided excellent care (56.5%). Overall, nurses perceived

that the quality of care being provided during their shift as excellent (62.5%). In Magnet organizations, nurses perceived that quality of care being provided during their shift as excellent (63.8%). In non-Magnet organizations, nurses perceived that quality of care being provided during their shift as excellent (59.2%). Also, nurses perceived that the quality of care has improved over the last year (35.9%). In Magnet organizations, nurses perceived that quality of care improved over the last year (35.4%). In non-Magnet organizations, nurses perceived that quality of care improved over the last year (37.1%). Finally, nurses perceived that patients could confidently to very confidently take care of themselves at home (70.1%). In Magnet organizations, nurses perceived that patients could confidently to very confidently take care of themselves at home (70.4%). In non-Magnet organizations, nurses perceived that patients could confidently to very confidently take care of themselves at home (68.9%). Table 11 provides specific information regarding perceptions about medication errors and quality of care in Magnet and non-Magnet organizations.

Table 11

*Perceptions about Quality of Care and Medication Errors*

<b>Measurement*</b>	<b>Magnet (n = 1003)</b>	<b>Non-Magnet (n = 402)</b>
Frequency of Medication Errors		
Never	526 (52.4)	189 (47.0)
Rarely	399 (39.8)	175 (43.5)
Sometimes	63 (6.3)	31 (7.7)
Frequently	4 (0.4)	5 (1.2)
Not indicated	11 (11.1)	2 (0.5)
Quality of Care delivered in the last shift		
Poor	1 (0.1)	4 (1.0)
Fair	45 (4.5)	31 (7.7)
Good	329 (32.8)	137 (34.1)
Excellent	608 (60.6)	227 (56.5)
Not indicated	20 (2.0)	3 (0.7)
Quality of Care provided during the shift		
Poor	0 (0.0)	2 (0.5)
Fair	32 (3.2)	16 (4.0)
Good	303 (30.2)	138 (34.3)
Excellent	640 (63.8)	238 (59.2)
Not indicated	28 (2.8)	8 (2.0)
Quality of Care over the last year		
Improved	355 (35.4)	149 (37.1)
Stayed the same	472 (47.1)	184 (45.8)
Declined	159 (15.9)	64 (15.9)
Not indicated	17 (1.7)	5 (1.2)
Patients prepared to take of self at discharge		
Not at all confident	25 (2.5)	6 (1.5)
Somewhat confident	248 (24.7)	115 (28.6)
Confident	504 (50.2)	194 (48.3)
Very confident	203 (20.2)	83 (20.6)
Not indicated	23 (2.3)	4 (1.0)

\*Note. All numbers are n (%). Sample size for each comparison varied from 1327 to 1392 due to missing data.

When addressing if acute nurses with baccalaureate or higher nursing degrees have higher levels of structural empowerment in Magnet organizations when compared to

non-Magnet organizations, a test of interaction from two-way ANOVA (analysis of variance) revealed no statistical significance ( $p = 0.395$ ). The relationship between education level, facility type, and high structural empowerment levels are shown in Figure 4.

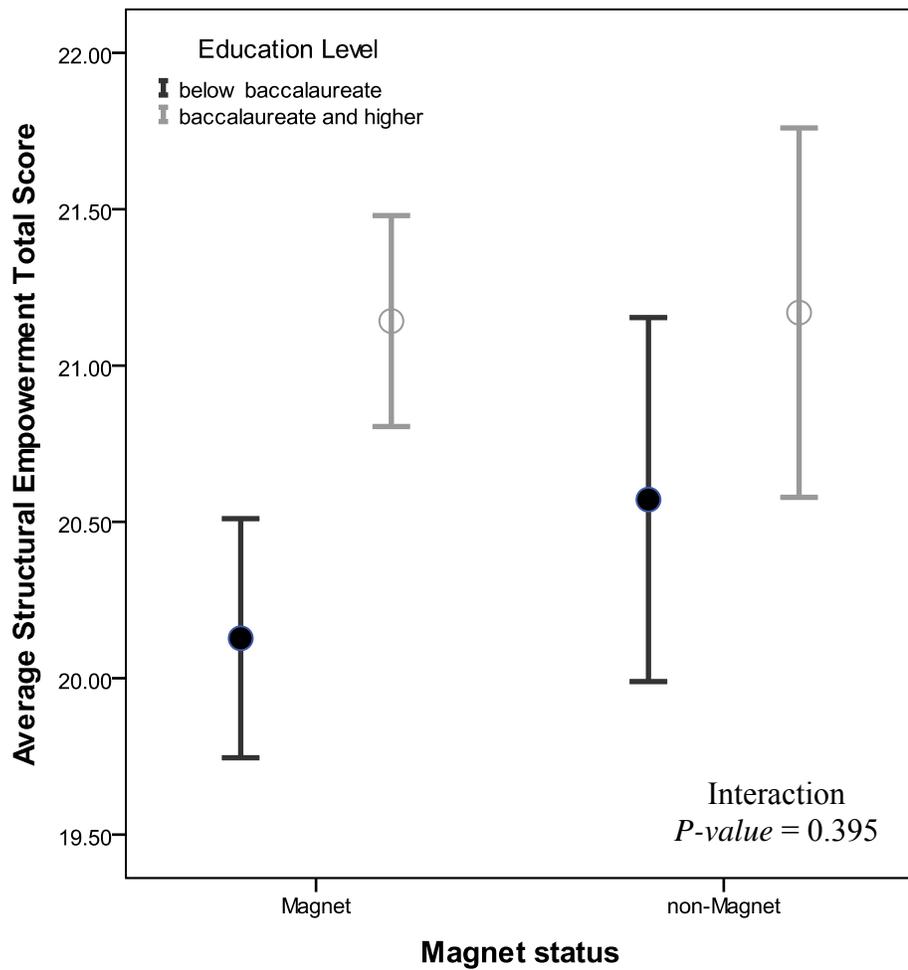


Figure 4. Error Plot of Education with Higher Levels of Structural Empowerment

Similarly examining the relationship between age, levels of structural empowerment levels, and Magnet status, a test of age by status interaction from two-way

ANCOVA revealed no statistical significance ( $p = 0.231$ ). The relationship between age and high structural empowerment levels by facility type is shown in Figure 5.

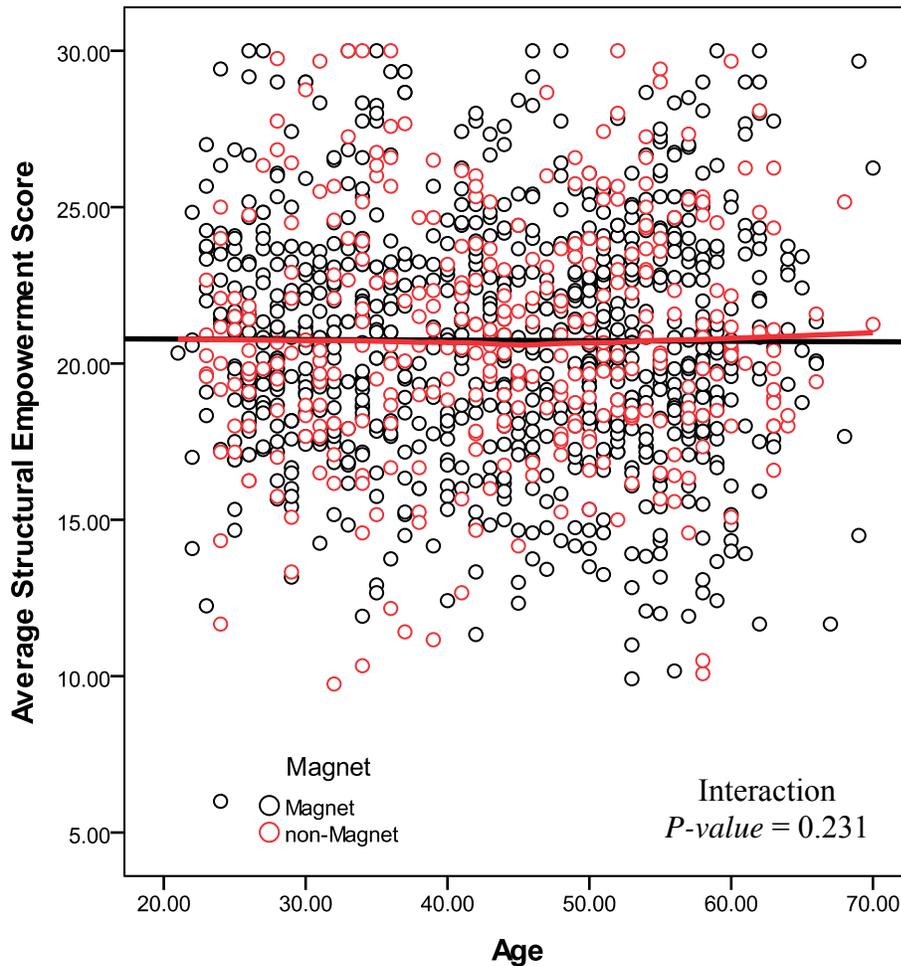


Figure 5. Scatterplot of Age with Higher Levels of Structural Empowerment.

When examining nurses who work full time versus those who do not work full time and comparing this grouping in Magnet organizations and non-Magnet organizations, a two-way ANOVA revealed no statistical significance ( $p = 0.693$ ). The

relationship between work status and high structural empowerment levels by Magnet status is shown in Figure 6.

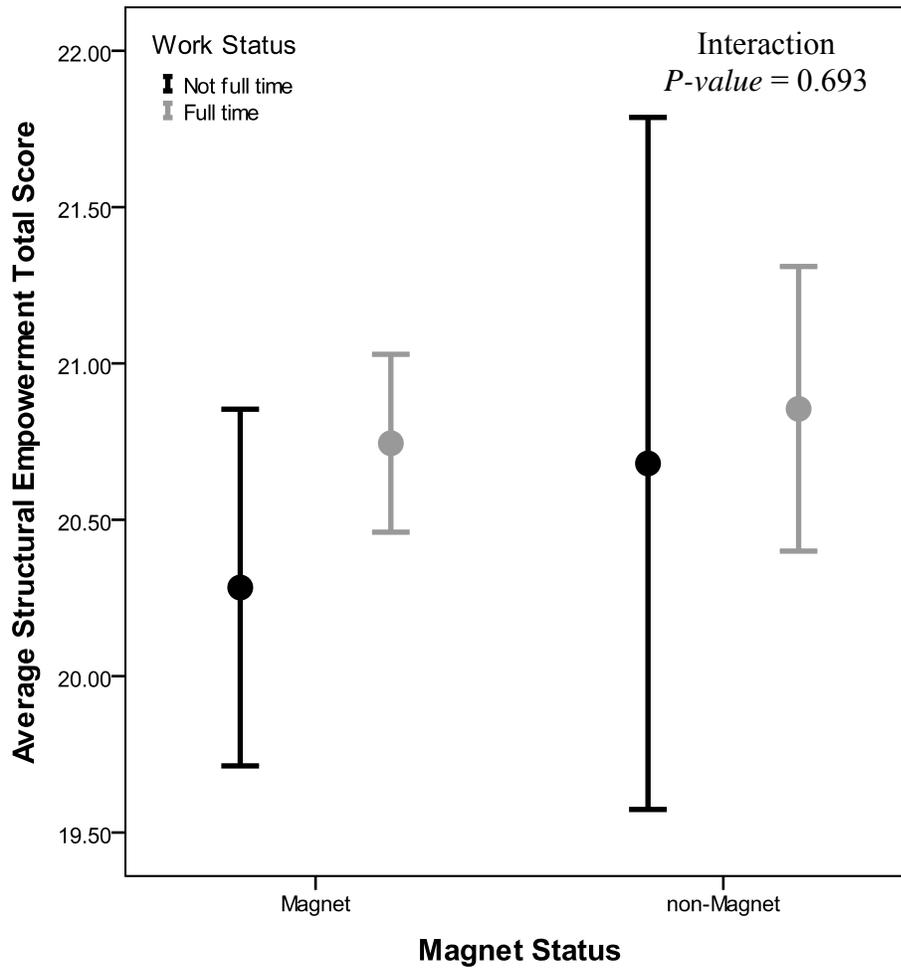
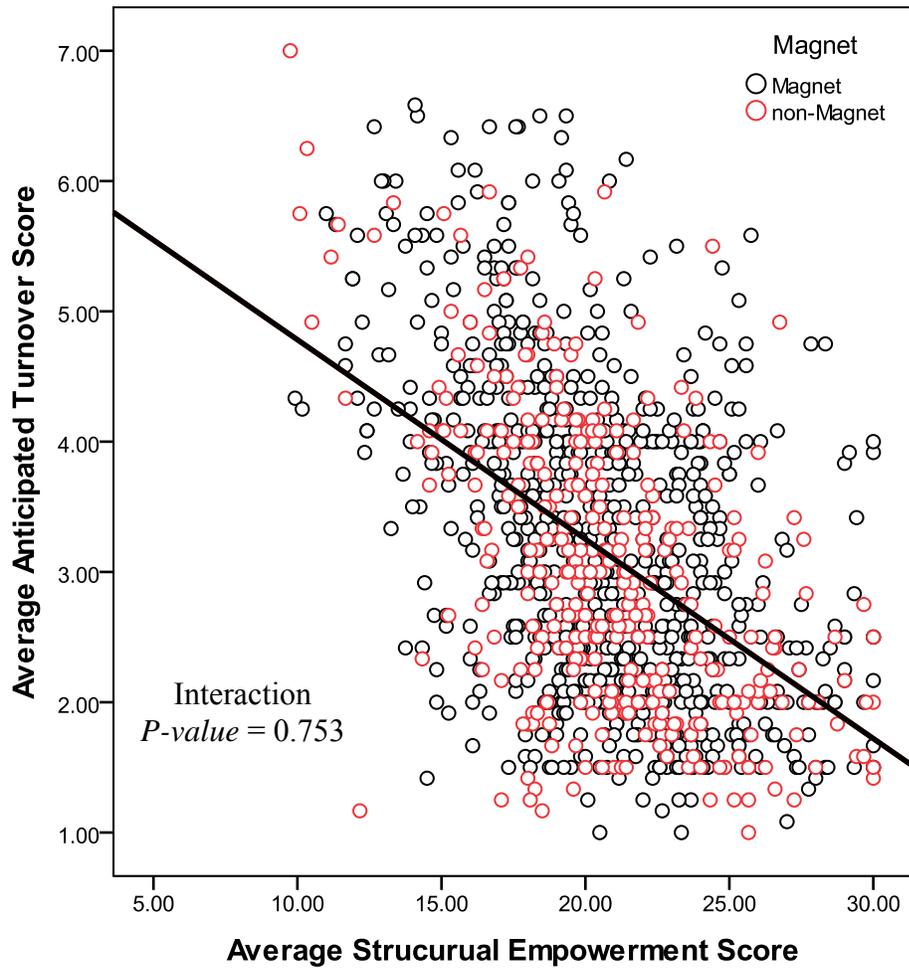


Figure 6. Error Bar Plot of Work Status with Higher Levels of Structural Empowerment.

In examining the relationship between levels of structural empowerment and anticipated turnover (less likely to turnover) in Magnet organizations and non-Magnet organizations, a test of empowerment by facility type interaction in two-way ANCOVA

revealed no statistical significance ( $p = 0.753$ ). The relationship between high levels of structural empowerment and anticipated turnover by Magnet status is shown in Figure 7.



*Figure 7. Scatterplot of Anticipated Turnover with Higher Levels of Structural Empowerment.*

Further, levels of structural empowerment in relation to higher job satisfaction according to Magnet versus non-Magnet organizations were similarly analyzed in a two-way ANCOVA. A test of the empowerment by facility type interaction revealed no

statistical significance ( $p = 0.679$ ). The relationship between high levels of structural empowerment and job satisfaction by type are shown in Figure 8.

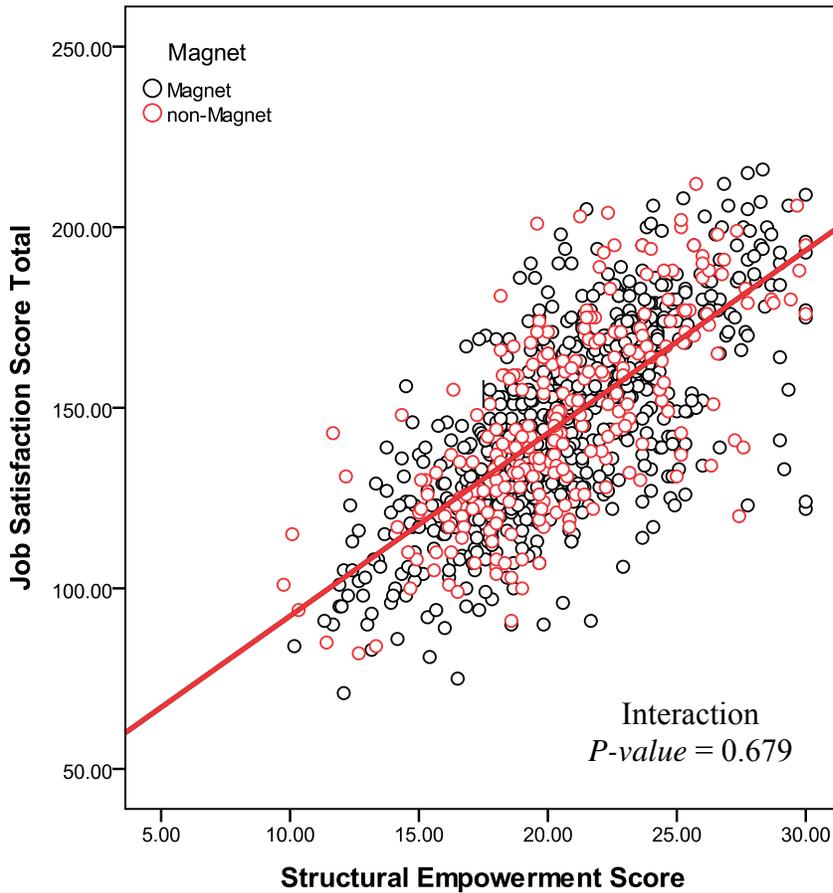


Figure 8. Scatterplot of Higher level of Structural Empowerment and Job Satisfaction.

Similarly analyses were performed for examining the relationships of structural empowerment by Magnet versus non-Magnet organizations for self-reported medication errors and changes in quality of care. Here, a test of interaction effects of structural empowerment by facility type using logistic regressions for these outcomes revealed no statistical significance. Analyses of self-reported medication errors within last year ( $p =$

0.752), quality of care during last shift ( $p = 0.793$ ), quality of care during current shift ( $p = 0.206$ ), quality of care over the last year as being improved ( $p = 0.745$ ), and very confident that patient can take care of self at discharge ( $p = 0.935$ ) revealed that differences in the predicted prevalence of perceived medication errors or quality of care between Magnet versus non-Magnet organizations did not depend upon structural empowerment scores. The relationships between high levels of structural empowerment (based upon score of 23 - 30 which define high levels of structural empowerment in the sample population), medication errors, and quality of care according to facility type are shown in Figures 9 – 13.

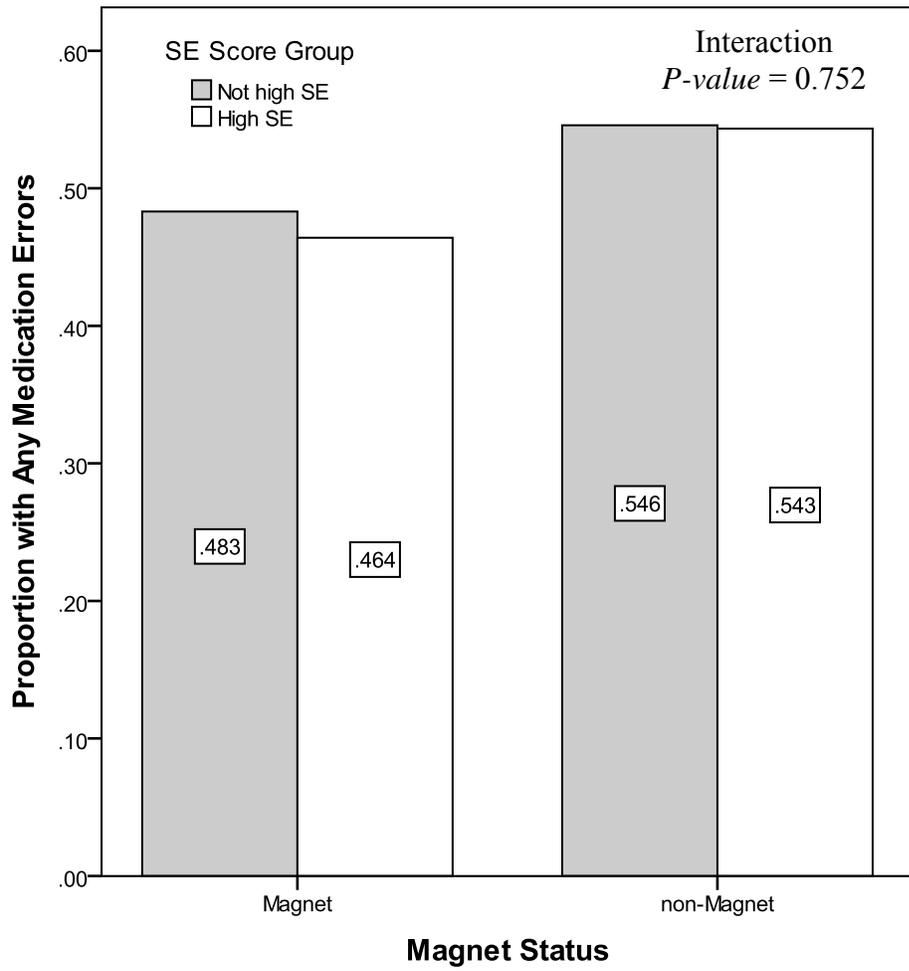


Figure 9. Bar Chart of Medication Errors and Higher Levels of Structural Empowerment.

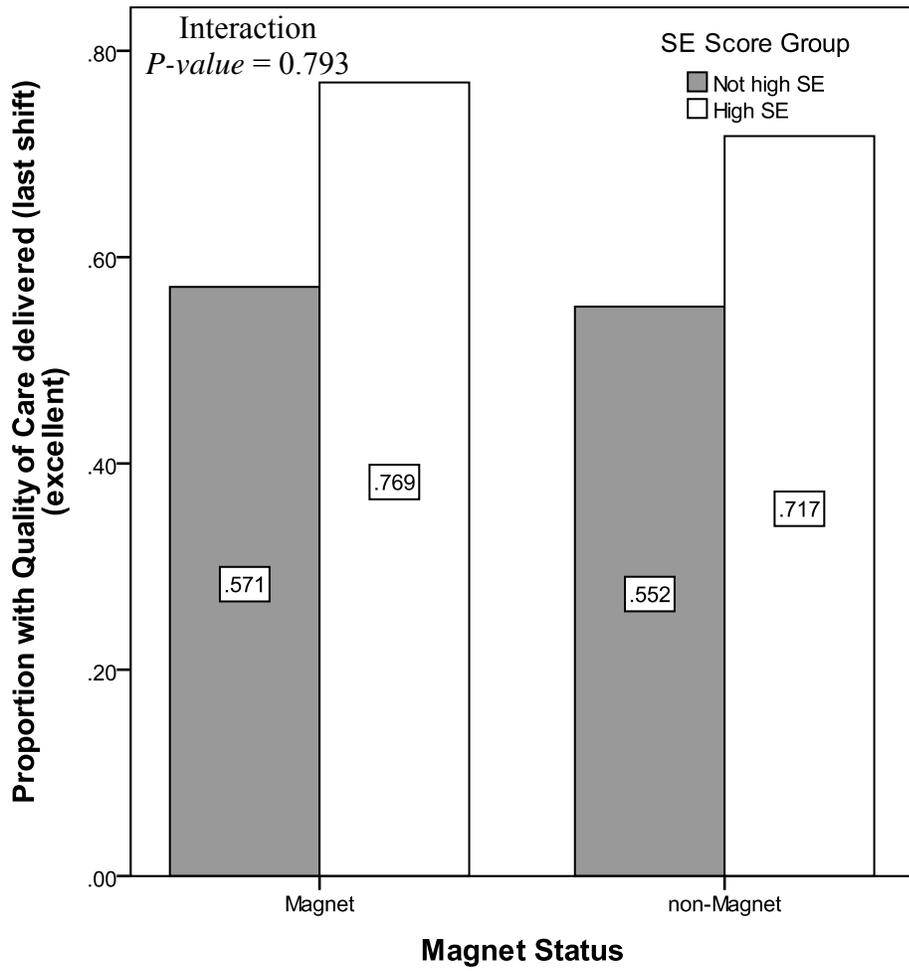


Figure 10. Bar Chart of Quality of Care (last shift) by Higher Levels of Structural Empowerment.

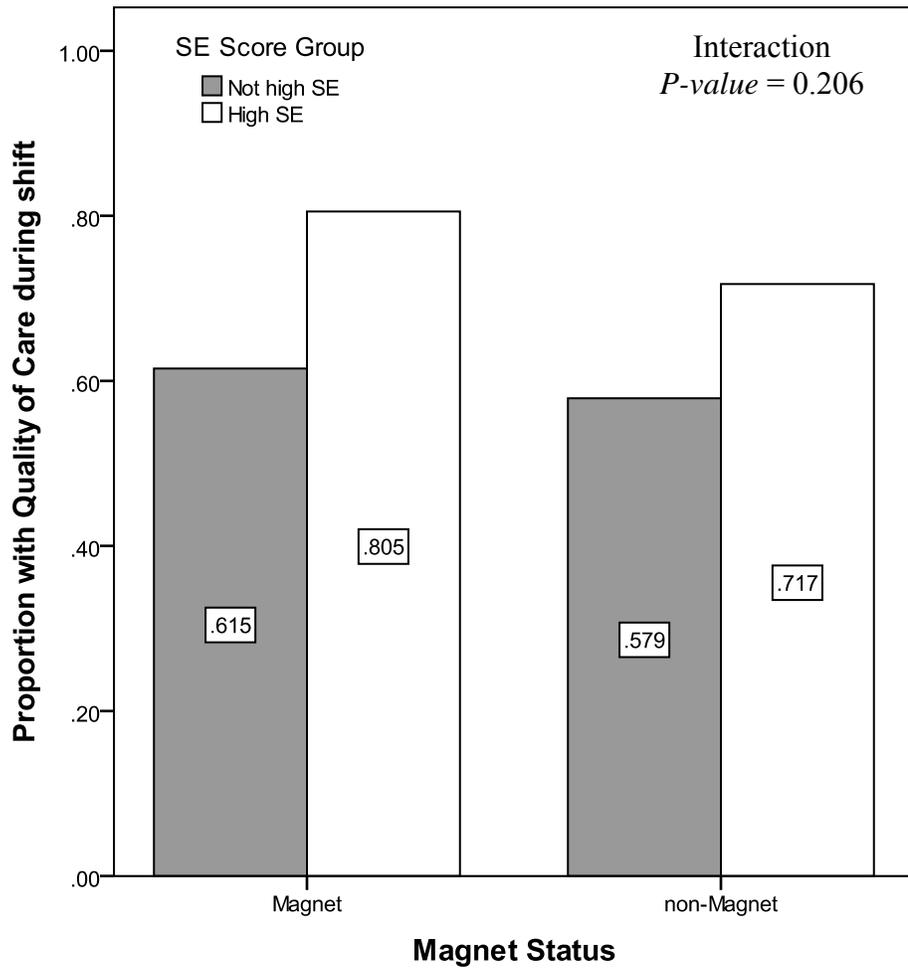


Figure 11. Bar Chart of Quality of Care (current shift) by Higher Levels of Structural Empowerment.

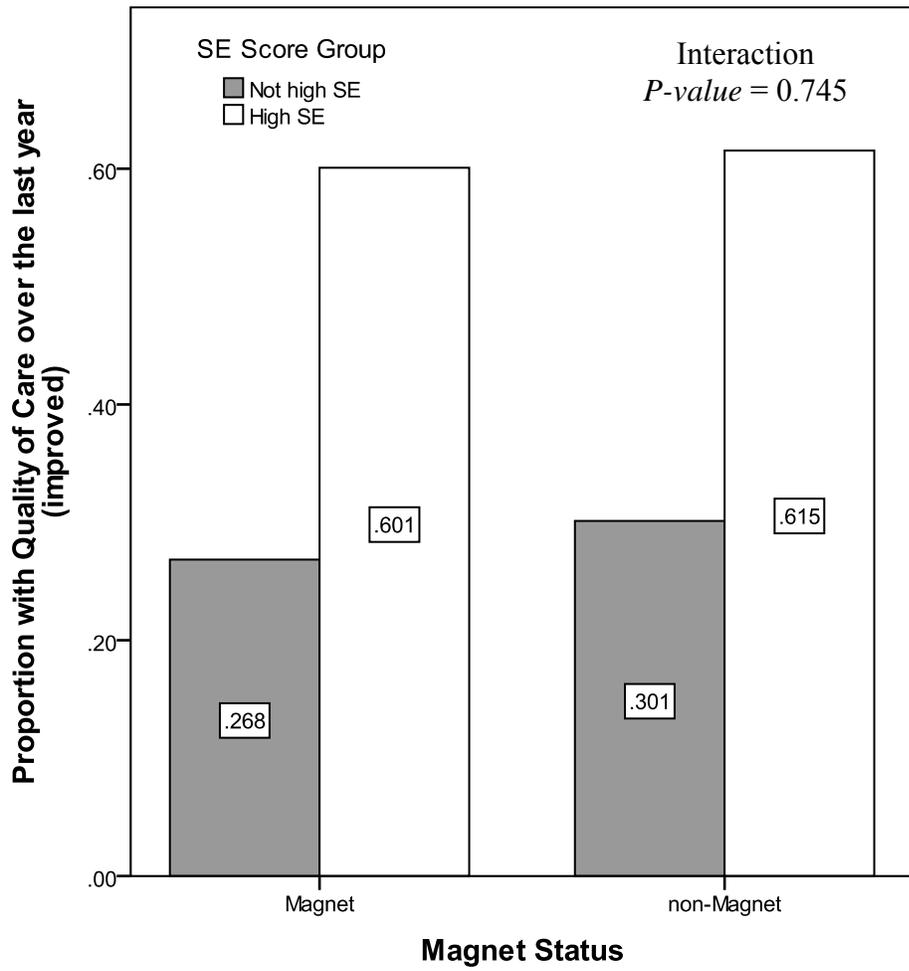


Figure 12. Bar Chart of Quality of Care (over the year) by Higher Levels of Structural Empowerment.

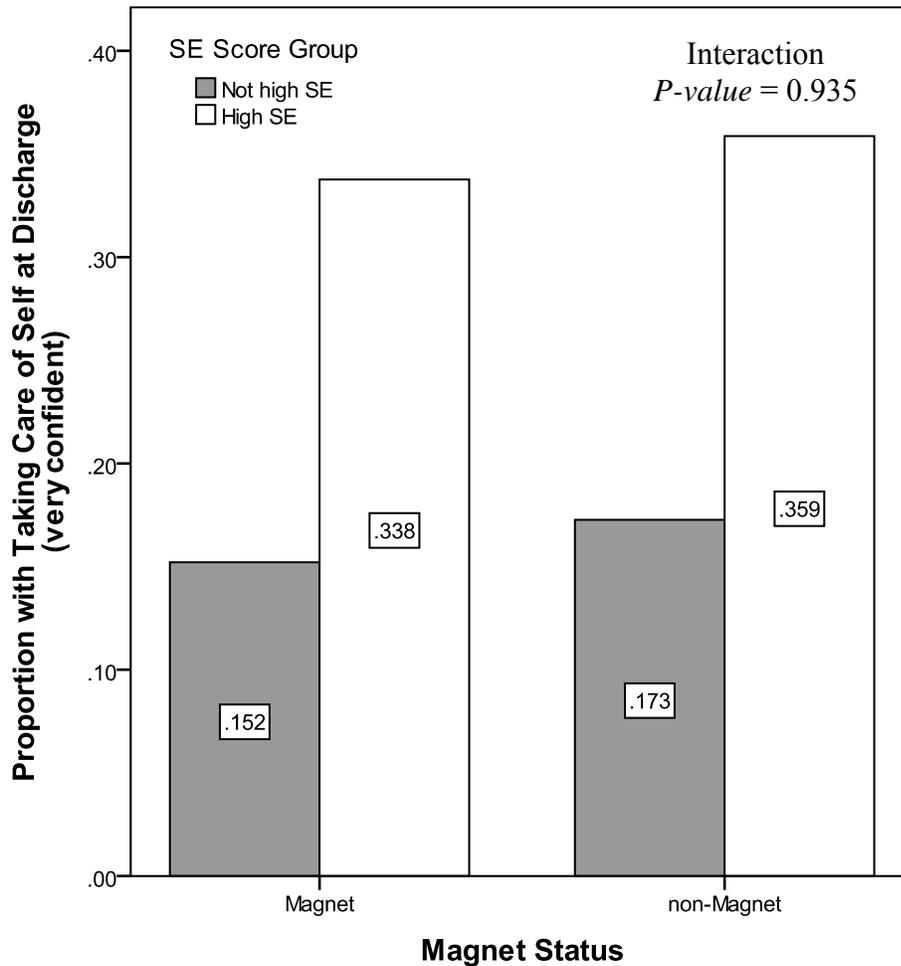


Figure 13. Bar Chart of Quality of Care (at discharge) by Higher Levels of Structural Empowerment.

## Discussion

### Structural Empowerment

Results of the Conditions of the Work Effectiveness – II questionnaire provided information concerning the state of the work environment and empowerment as described by Kanter (1977). Empowerment scores, total and subscales, were good and advocate that nurses had varying access to Kanter’s empowerment structures within the

organization. In a previous study, Laschinger (2008) found that nurses were moderately empowered ( $M = 19.14$ ;  $SD = 3.3$ ) and nurses believe that access to opportunity was the highest component ( $M = 4.05$ ;  $SD = 0.75$ ) in the Kanter's theory. When comparing Magnet and non-Magnet organizations in this study, nurses did rate empowerment as being moderate ( $M = 20.7$ ;  $SD = 3.86$ ) in Magnet and moderate ( $M = 20.9$ ;  $SD = 3.86$ ) in non-Magnet. Both types of organizations did show that access to opportunity as being the highest subscale which means that nurses have the opportunity to professionally grow and advance within the organization. This indicates that nurses have opportunities for gaining new knowledge and skills and for serving the organizations through meetings and councils. With the two organizations reporting access to resources as the least favorable category, organizations will need to provide the necessary equipment and supplies so that nurses can complete their job responsibilities more efficiently. Findings from other studies were similar to the results of empowerment scores in this study (Faulkner & Laschinger, 2008; Laschinger, 2008; Laschinger, Leiter, Day, Gilin-Oore, & Mackinnon, 2012; McDonald et al., 2010).

Even though their study did not specifically compare Magnet and non-Magnet organizations, Faulkner and Laschinger (2008) reported that empowered nurses who feel more respected in the work environment will be satisfied and committed. In this current study, the results were very similar with non-Magnet organizations having a slightly higher mean. The components of the Structural Empowerment Theory mirrored one another in both types of organizations. There was no statistical significance ( $p = 0.492$ )

between average total structural empowerment scores between the two types of organizations.

Other measures were also analyzed with empowerment scores to see if a relationship existed. Magnet organizations stress the importance of opportunities such as education (Kramer & Schmalenberg, 2004a). Nurses working in Magnet organizations did overall have more baccalaureate or higher degrees (57%) in comparison to non-Magnet nurses. When interpreting education levels between both organizations, nurses with baccalaureate or higher degrees were more prevalent in Magnet organizations; however, the means were no significantly different by both types of organizations ( $p = 0.395$ ). Nurses working in Magnet organizations average age ( $M = 43.7$ ;  $SD = 11.8$ ) was similar to the average age of non-Magnet nurses ( $M = 43.8$ ;  $SD = 11.6$ ). When reviewing the relationship between age with higher empowerment scores in both types of organizations, the scores mirrored one another with no statistical significance ( $p = 0.231$ ). Nurses work status of full time in Magnet organizations (83%) was similar to the full time work status of non-Magnet nurses (84%). When interpreting work status between both organizations, the means were very similar in both types of organizations with no statistical significance ( $p = 0.693$ ). In essence, the overall results indicate that structural empowerment's relationship with work status, education status, and age was comparable in both types of facilities.

### **Job Satisfaction**

Results of the Job Satisfaction Scale (JSS) provided information concerning the state of how nurses feel about their work environment. Findings regarding JSS scores,

total and subscales, were mixed. Nurses in both types of organizations agreed that the nature of work was the highest subscale as this subscale addressed job tasks. Nurses from both types of organizations differed in the least favorable subscale as Magnet nurses reported pay, focusing on pay and remuneration, to be the least favorable and non-Magnet nurses reported promotions, focusing on promotion opportunities, to be the least favorable. When comparing Magnet and non-Magnet organizations in this study, nurses did perceive job satisfaction as being slightly satisfying ( $M = 146.01$ ;  $SD = 27.18$ ). Magnet nurses had an average total score of 145.89 ( $SD = 26.98$ ) and non-Magnet nurses had an average score of 146.36 ( $SD = 27.79$ ). There was no statistical difference when comparing both types of organizations when looking at total job satisfaction scores ( $p = 0.810$ ). The American Nurses Credentialing Center claims that one of the benefits of Magnet designation includes attracting and retaining top talent, improving patient care, safety, and satisfaction, and fostering a collaborative culture (retrieved on 9/14/4 from <http://www.nursecredentialing.org/Magnet/ProgramOverview>). Retaining talent involves having satisfied employees. Results from this study show that Magnet and non-Magnet organizations are similar in job satisfaction scores according to the JSS ( $p = 0.810$ ). The subscales from this instrument were similar in both types of organizations with no statistical significance in any subscale.

### **Intent to Stay**

Intent to stay was measured through considering anticipated turnover. When comparing Magnet and non-Magnet organizations in this study, nurses did rate anticipated turnover as less likely of terminating their employment in the organization.

Magnet nurses had a mean score of 3.12 (SD = 1.20) and non-Magnet nurses had a mean score of 3.06 (SD = 1.19). There was no statistical difference when comparing both types of organizations when looking at anticipated turnover scores ( $p = 0.096$ ). The American Nurses Credentialing Center claims that one of the benefits of Magnet designation includes attracting and retaining top talent (retrieved on 9/14/4 from <http://www.nursecredentialing.org/Magnet/ProgramOverview>). Retaining employees is important in any organizations. Results from this study show that Magnet and non-Magnet organizations are similar in keeping their employees within the organization according to the Anticipated Turnover Scale ( $p = 0.096$ ). When looking at the relationship between anticipated turnover and structural empowerment scores, this relationship did not depend upon organization facility type ( $p = 0.753$ ). A finding from another study supported the results of this research as the finding was similar to the result of the relationship between anticipated turnover and empowerment scores in this study (Hauck et al., 2011).

### **Perceptions about Medication Errors and Quality of Care**

When comparing Magnet and non-Magnet organizations in this study, nurses did perceive quality outcomes similarly. Both types of organizations reported the highest about never having a medication error within the last year. Magnet nurses were at 52.4% reporting whereas non-Magnet nurses were at 47.0% reporting. Magnet nurses reported that they rarely had a medication error within the last year (39.8%) whereas non-Magnet nurses reported 43.5%.

Perceived quality of care provided some interesting results. When assessing quality of care between both types of organizations, Magnet nurses reported quality of care delivered on the last shift as excellent (60.6%), quality of care delivered during the shift as excellent (63.8%), quality of care improved over the last year (35.4%) and confident to very confident that patients could take care of themselves at discharge (80.4%). Non-Magnet nurses reported quality of care delivered on the last shift as excellent (56.5%), quality of care delivered during the shift as excellent (59.2%), quality of care improved over the last year (37.1%) and confident to very confident that patients could take care of themselves at discharge (68.9%). Concerning in the results is the fact that nurses in both types of organizations reported that quality of care had declined (15.9%). As healthcare organizations struggle to cut costs, nurse administrators will need to address this concern as quality of care will have to be continually improved for reimbursements to occur. Overall, results from this study did indicate that quality of care was perceived to be better in Magnet organizations as percentages were higher in all categories except for quality of care over the last year.

### **Implications**

The results of this study provide a valuable description about whether or not a difference exists between Magnet and non-Magnet organizations. Outcomes assessed included structural empowerment, job satisfaction, anticipated turnover, and quality of care measures. These measurements compared the two different types of organizations to see whether or not a difference truly existed and where opportunities for improvement are needed. This information may assist other healthcare organizations in deciding about

whether or not Magnet designation needs to be achieved or not. This research does provide guidance as to how nurses feel about their work environment. More research is needed to compare Magnet and non-Magnet organizations where similar institution can be compared.

### **Study Limitations**

The limitations associated with this research study must be considered with any interpretations. This study involved 21 healthcare organizations. Two corporate hospital organizations comprised 20 of the 21 hospitals participating with both corporations having both types of organizations, Magnet and non-Magnet facilities. Some non-Magnet hospitals were on the pathway of excellence for Magnet designation. Another limitation is that the environment from the healthcare organization may be different. Magnet organizations tended to reside in urban environments whereas non-Magnet organizations tended to reside in rural environments. The population served, as well as the size of the facility, by these different facilities varied which could certainly influence the perceptions of nurses regarding work environment and quality of care. Another limitation involved the length of the survey and completion rates. Questions at the end of the survey tended to be left blank as the survey was comprised of four instruments and a demographic section. Finally, an electronic survey was used for this survey and a malfunction was detected in the first few days of survey distribution which may have prevented some nurses from completing the survey.

## **Conclusion**

This study provides comprehensive, descriptive and comparable information on nursing environments within 21 Magnet or non-Magnet healthcare organizations. The results of this study indicate that there are no statistical significance differences existing between Magnet and non-Magnet organizations when looking at structural empowerment's influence on nursing outcomes. Findings provide empirical evidence that both types of organizations are similar when assessing empowerment's influence of the work environment. The results provide insight as to how nurses view empowerment in their organization and as well as how they perceive outcomes within their respective institution. There are areas that need to be further addressed if healthcare administrators desire to retain the best staff and provide satisfaction within the work environment. Improving on aspects of the work environment could assist in promoting retention of employees while also improving job satisfaction. Structural empowerment is detrimental in the workplace as nurses desired to be empowered in decision-making. Moreover, further exploration needs to be conducted to see what Magnet facilities can implement to make their claim as being superior in outcomes for future outcomes.

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Improving on aspects of the work environment could assist in promoting retention of employees while also improving job satisfaction. Structural empowerment is important in the workplace as nurses desired to be empowered in decision-making. Moreover, further exploration needs to be conducted to see what Magnet facilities can implement to make their claim as being superior in outcomes for future outcomes.

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## APPENDIX A

### SURVEY

*Survey copied from Qualtrics*

#### Participant Information Sheet:

This electronic survey will be examining organizational empowerment's influence on job satisfaction, intent to stay, and perceptions about quality of care for nurses working in acute care facilities. This electronic survey consists of 117 questions and will take no longer than 30 minutes. The information collected will be used to answer the following research questions:

1. What is the level of structural empowerment of acute care nurses in Magnet and non-Magnet hospitals?
2. What is the level of the practice environment of acute care nurses in Magnet and non-Magnet hospitals?
3. What is the intent to stay level of acute care nurses in Magnet and non-Magnet hospitals?
4. What is the level of job satisfaction of acute care nurses in Magnet and non-Magnet hospitals?
5. What is the rate of making a medication error (self-reported) with Magnet and non-Magnet facilities reported by acute care nurses?
6. What is the quality of care (self-reported) with Magnet and non-Magnet facilities reported by acute care nurses?

Nurses within the selected, identified hospitals are invited to participate in this research study that is being conducted electronically. As for inclusion/exclusion criteria, any nurse can participate in this study as long as they are over the age of 18. The benefit of this study will be to see if a difference exists between Magnet and non-Magnet organizations when looking at structural empowerment and different measurement outcomes.

Data collected from this survey will be shared with the organizations in the aggregate selecting to participate in this research. Dissemination of the results (publication) also will be shared with any deemed appropriate nursing organization that caters to the nursing workforce. All information obtained from this study will be kept on a password protected computer that only the principal investigator can access.

All information obtained in this study is strictly confidential unless disclosure is required by law and will be kept anonymous. Absolute confidentiality of data provided through the Internet cannot be guaranteed due to the limited protections of Internet access. Please be sure to close your browser when finished so no one will be able to see what you have been doing. The decision to participate is strictly voluntary. You have the right to refuse to participate or to

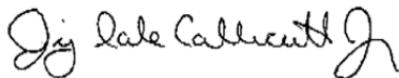
withdraw at any time, without penalty. If you do withdraw, it will not affect you in any way. There will be no identifications, tags, or IP addresses that will link any participant to the actual responses for the research questions. The Institutional Review Board at the University of North Carolina at Greensboro has determined that participation in this study poses minimal risk to participants.

At the completion of the survey, you will have the opportunity to be entered into a \$50 gift card drawing. If you desire to be entered into this drawing, the last question of the initial survey will redirect you to another survey link which will collect information for contact purposes only. Your name, email, and phone number will be collected. This information only will be collected for those desiring a chance of winning a gift card.

By participating in this electronic survey, you are agreeing that you read, or it has been read to you, and you fully understand the contents of this document and are openly willing consent to take part in this study. All of your questions concerning this study have been answered. By participating in the survey, you are agreeing that you are 18 years of age or older and are agreeing to participate.

This study is being conducted by Dale Callicutt, RN who currently is a doctoral student at UNC-Greensboro. I can be reached at 336.817.6974 (c) or 336.718.5229 (w) or via email at [jdcallicut@novanthealth.org](mailto:jdcallicut@novanthealth.org). Dr. Susan Letvak is my advisor's name and she can be reached at 336.256.1024. If you have any concerns about your rights, how you are being treated, concerns or complaints about this project or benefits or risks associated with being in this study please contact the Office of Research Integrity at UNCG toll-free at 855.251.2351.

Thank you.



---

Job Descriptive(s) (13)

Hospital

Cone Health

Alamance Regional Hospital  
Annie Penn Hospital  
Behavioral Health Hospital  
Moses Cone Hospital  
Wesley Long Hospital  
Women's Hospital

Novant Health

Brunswick Medical Center  
Charlotte Orthopedic Hospital  
Clemmons Medical Center  
Forsyth Medical Center  
Franklin Medical Center  
Haymarket Medical Center  
Hemby Medical Center  
Huntersville Medical Center  
Kernersville Medical Center  
Matthews Medical Center  
Medical Park Hospital  
Presbyterian Medical Center  
Prince Williams Medical Center  
Rowan Medical Center  
Thomasville Medical Center  
Randolph Hospital

Is your hospital facility on the pathway program for Magnet?      Yes      No

Gender.

Female  
Male

Please list your age numerically.

How many years have you been in nursing? (please use a numerical number).

How many years have you been in your current role? (please use a numerical number)

How many years have you been on your current nursing unit? (please use a numerical number).

How many hours do you work in a typical work week? (please use a numeric number)

What is the length of the shift **that you** normally work?

< 8 hours      8 - 10 hours      > 10 hours

What shift do you normally work?

Day time (majority of time between 7a – 7p)

Evening/Night (majority of time between 7p – 7a)

Classification of your work status.

Full time      Part time      PRN

Primary unit worked on

Administration / Management

Clinical inpatient area

Data collector or research

Education

Outpatient or Clinic

Procedural / Surgery

Other:

What is your professional nursing role at your organization?

Administrator or Management

Data Collector or Researcher

Educator

Staff nurse

Other: \_\_\_\_\_

What is the highest level of **nursing** education?

Diploma      Associate degree      Baccalaureate degree

Master's  
degree or above

Structural Empowerment (21) [CWEQ instrument]

	None		some		a lot
	1	2	3	4	5
How much of each kind of <u>opportunity</u> do you have in your present job?					
Challenging work					
The chance to gain new skills and knowledge on the job					
Tasks that use all of your own skills and knowledge					
	No		Some		Know
	knowledge		knowledge		a lot
	1	2	3	4	5
How much access to <u>information</u> do you have in your present job?					
The current state of hospital					
The values of top management					
The goals of top management					
	None		some		a lot
	1	2	3	4	5
How much access to <u>support</u> do you have in your present job?					
Specific information about things you do well					
Specific comments about things you could improve					
Helpful hints or problem solving advice					
	None		some		a lot
	1	2	3	4	5
How much access to <u>resources</u> do you have in your present job?					
Time available to do necessary paperwork					
Time available to accomplish job requirements					
Acquiring temporary help when needed					
	None				A lot
	1	2	3	4	5
In my current setting/job:					
The rewards for innovation on the job are					
The amount of flexibility in my job is					
The amount of visibility of my work-related activities within the institution is					
	None				A lot
	1	2	3	4	5
How much opportunity do you have for these activities in you present job?					
Collaborating on patient care with physicians					
Being sought out by peers for help with problems					
Being sought out by managers for help with problems					
Seeking out ideas from professionals other than physicians					
(e.g., Physiotherapists, Occupational Therapists, Dieticians)					

Strongly  
Disagree                      Strongly  
1            2            3            4            5  
Agree

Overall, my current work environment empowers me to accomplish my work in an effective manner

Overall, I consider my workplace to be an empowering environment.

Practice Environment Scale (31) [PES instrument]

For each item, please indicate the extent to which you agree that the item is PRESENT IN YOUR CURRENT JOB. Indicate your degree of agreement by selecting the appropriate number.

Strongly Agree	Agree	Disagree	Strongly Disagree
1	2	3	4

- Adequate support services allow me to spend time with my patients.
- Physicians and nurses have good working relationships.
- A supervisory staff that is supportive of the nurses.
- Active staff development or continuing education programs for nurses.
- Career development/clinical ladder opportunity.
- Opportunity for staff nurses to participate in policy decisions.
- Supervisors use mistakes as learning opportunities, not criticism.
- Enough time and opportunity to discuss patient care problems with other nurses.
- Enough registered nurses to provide quality patient care.
- A nurse manager who is a good manager and leader.
- A chief nursing officer who is highly visible and accessible to staff.
- Enough staff to get the work done.
- Praise and recognition for a job well done.
- High standards of nursing care are expected by the administration.
- A chief nursing officer equal in power and authority to other top-level hospital executives.
- A lot of team work between nurses and physicians.
- Opportunities for advancement.
- A clear philosophy of nursing that pervades the patient care environment.
- Working with nurses who are clinically competent.
- A nurse manager who backs up the nursing staff in decision making, even if the conflict is with a physician.
- Administration that listens and responds to employee concerns.
- An active quality assurance program.
- Staff nurses are involved in the internal governance of the hospital (e.g., practice and policy committees).
- Collaboration (joint practice) between nurses and physicians.
- A preceptor program for newly hired RNs.
- Nursing care is based on a nursing, rather than a medical, model.
- Staff nurses have the opportunity to serve on hospital and nursing committees.
- Nursing administrators consult with staff on daily problems and procedures.
- Written, up-to-date nursing care plans for all patients.
- Patient care assignments that foster continuity of care, i.e., the same nurse cares for the patient from one day to the next.
- Use of nursing diagnoses.

Anticipated Turnover Scale [12] [ATS instrument]

Strongly Disagree (1)  
Moderately Disagree (2)  
Slightly Disagree (3)  
Uncertain (4)  
Slightly Agree (5)  
Moderately Agree (6)  
Strongly Agree (7)

- I plan to stay in my current position.
- I am quite sure I will leave my position in the foreseeable future.
- Deciding to stay or leave my position is not a critical issue for me at this point of time.
- I know whether or not I'll be leaving this organization with a short time.
- If I got another job offer tomorrow, I would give it serious consideration.
- I have no intentions to leaving my present position.
- I have been in my position about as long as I want to.
- I am certain I will be staying here a while.
- I don't have any specific idea how much longer I will stay.
- I plan to hang on to this job a while.
- There are big doubts in my mind as to whether or not I will really stay in the organization.
- I plan to leave this position shortly.

Job Satisfaction Survey (36) [JSS instrument]

Disagree Very Much (1)

Disagree Moderately (2)

Disagree Slightly (3)

Agree Slightly (4)

Agree Moderately (5)

Agree Very Much (6)

- I feel I am being paid a fair amount for the work I do.
- There is really too little chance for promotion on my job.
- My supervisor is quite competent in doing his/her job.
- I am not satisfied with the benefits I receive.
- When I do a good job, I receive the recognition for it that I should receive.
- Many of our rules and procedures make doing a good job difficult.
- I like the people I work with.
- I sometimes feel my job is meaningless.
- Communications seem good within this organization.
- Raises are too few and far between.
- Those who do well on the job stand a fair chance of being promoted.
- My supervisor is unfair to me.
- The benefits we receive are as good as most other organizations offer.
- I do not feel that the work I do is appreciated.
- My efforts to do a good job are seldom blocked by red tape.
- I find I have to work harder at my job because of the incompetence of people I work with.
- I like doing the things I do at work.
- The goals of this organization are not clear to me.
- I feel unappreciated by the organization when I think about what they pay me.
- People get ahead as fast here as they do in other places.
- My supervisor shows too little interest in the feelings of subordinates.
- The benefit package we have is equitable.
- There are few rewards for those who work here.
- I have too much to do at work.
- I enjoy my coworkers.
- I often feel that I do not know what is going on with the organization.
- I feel a sense of pride in doing my job.
- I feel satisfied with my chances for salary increases.
- There are benefits we do not have which we should have.
- I like my supervisor.
- I have too much paperwork.
- I don't feel my efforts are rewarded the way they should be.
- I am satisfied with my chances for promotion.
- There is too much bickering and fighting at work.
- My job is enjoyable.

- Work assignments are not fully explained.

Never	Rarely	Occasionally	Frequently
1	2	3	4

Self-reported Medication error

How frequently does the following safety problem occur among patients under your care over the past year?

Medication error (wrong medication or wrong dose administered)

Poor	Fair	Good	Excellent
1	2	3	4

Perception of quality of care

In general, how would you describe the quality of care of nursing care delivered to patients on your unit on your last shift?

Poor	Fair	Good	Excellent
1	2	3	4

Rate the quality of care during their last shift.

1	2	3
Improved	Stayed the same	Declined

Over the last year, has the quality of care on the unit:

Not at all confident	somewhat confident	confident	very confident
1	2	3	4

How confident that your patients are sufficiently prepared to take care of themselves at the time of discharge?

**Thank you for completing this survey. Your input was highly appreciated. The information obtained from this survey will be confidential and anonymous. By clicking 'continue', your information will be recorded and you will be directed to a separate survey.**

**If you desire to be entered into the drawing for a \$50 gift card, just continue answering the three remaining questions. These three questions will not be linked to any responses that you previously responded to.**

## APPENDIX B

### PERMISSION LETTERS



I request permission to copy the Nursing Work Empowerment Scale as developed by Dr. G. Chandler and Dr. Heather K. Spence Laschinger. Upon completion of the research, I will provide Dr. Laschinger with a brief summary of the results, including information related to the use of the Nursing Work Empowerment Scale used in my study.

Questionnaires Requested:

Conditions of Work Effectiveness-I (includes JAS and ORS):

Conditions of Work Effectiveness-II (includes JAS-II and ORS-II): Yes

Job Activity Scale (JAS) only: Yes

Organizational Relationship Scale (ORS) only:

Organizational Development Opinionnaire or Manager Activity Scale:

Other Instruments:

Please complete the following information:

Date: 10/25/2014

Name: Dale Callicutt

Title: Structural Empowerment's Influence on Two Nursing Sensitive Indicators, job Satisfaction and Intent to Stay, and Two Quality of Care Measures, Medication Errors and Quality of Care, in Magnet and non-Magnet Organizations.

University/Organization: University of North Carolina at Greensboro

Address: 725 Blackwood Avenue

Winston-Salem, North Carolina 27103

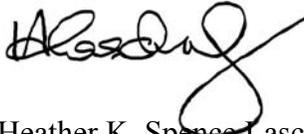
Phone: 336.718.5229

E-mail: [jdcalicutt@novanthealth.org](mailto:jdcalicutt@novanthealth.org)

Description of Study: I am thankful to have used the CWEQ-II instrument with my pilot study last spring. As I work on my dissertation for doctoral school, I want to use this tool again. I plan to look at two major hospital organizations within my geographical location as well as some minor facilities within a 50 mile radius. Some of these organizations are

Magnet and some are non-Magnet. My intent to see if structural empowerment, which is one of the pillars of Magnet, is prevalent more in these measurements/outcomes as emphasized by the ANCC when comparing the organizations. (FYI, my title might change but the topic will not.)

Permission is hereby granted to copy and use the Nursing Work Empowerment Scale.  
Date: November 5, 2014

A handwritten signature in black ink, appearing to read "H. Spence Laschinger". The signature is fluid and cursive, with a large loop at the end.

Dr. Heather K. Spence Laschinger, Professor  
School of Nursing, University of Western Ontario  
London, Ontario, Canada N6A 5C1  
Tel: 519-661-2111 ext.86567  
Fax: 519-661-3410  
E-mail: hkl@uwo.ca

The JSS is provided free for noncommercial educational and research purposes.

Job Satisfaction Survey, copyright Paul E. Spector, 1994, All rights reserved.

October 8, 2001

Date: November 4, 2014

To: Dale Callicutt

From: Evelyn Perloff, PhD

Enclosed is the:

Anticipated Turnover Scale  
Ada Sue Hinshaw & Jan R. Atwood

As I have indicated authors like to receive feedback on your study. All that is asked is that you provide a brief summary of your findings upon completion of your study/project. In addition, we encourage you to send a full report which we will consider for inclusion in Health and Psychosocial Instruments (HaPI) and which you may list on your vita/resume.

You have the author's permission to use the above instrument.

Please note that the instruments are for a single study only. It is, of course, necessary to provide the appropriate title and author credit in reproduced material and in your report.

PO Box 110287 Pittsburgh, PA 15232-0787  
Phone: 412-687-6850 Fax: 412-687-5213 E-mail: bmdshapi@aol.com

From: Barol, Andrea <ajb@nursing.upenn.edu>  
Sent: Wednesday, October 22, 2014 10:38 AM  
To: Callicutt, Dale  
Subject: RE: Permission needed  
Attachments: PES-NWI subscales and scoring.doc; Practice Environment Scale of the Nursing Work Index.doc; Warshawsky & Havens 2010\_NursingResearch PES NWI.pdf

Dear Dale Callicutt:

Thank you for your inquiry. I am replying on behalf of Dr. Eileen Lake. Enclosed, please find the instrument, scoring instructions, an article containing PES-NWI scores for ANCC Magnet hospitals from 1998 in Table 1, and a Warshawsky & Haven article you may find useful. These materials are sent to everyone who makes the request.

Dr. Lake's permission is not needed as the instrument is in the public domain due to its endorsement by the National Quality Forum in 2004 and re-endorsement in 2009: <http://www.qualityforum.org/QPS/QPSTool.aspx?m=1129&e=3>. However, if you prefer to have Dr. Lake's permission, this email serves as her permission.

Please direct any reply to Dr. Eileen Lake at [elake@nursing.upenn.edu](mailto:elake@nursing.upenn.edu). If you need anything else, feel free to write to us again.

Andrea Barol  
Administrative Coordinator  
Center for Health Outcomes and Policy Research  
University of Pennsylvania School of Nursing  
418 Curie Boulevard, Room 378  
Philadelphia, PA 19104  
215-898-4727 (Office)  
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